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ABSTRACT

In 1993, nine states were awarded Making the Grade grants to develop financial and other strategies to foster replication of school-based health centers (SBHCs). This report details the financial strategies used by Vermont, Rhode Island, Oregon, North Carolina, New York, Maryland, Louisiana, Connecticut, and Colorado, as reported in a meeting of grant recipients in 1998. Following an executive summary, the report describes the strategies taken by each state. The report notes that with the exception of Louisiana, these states directed their attention to linking SBHCs to Medicaid managed care arrangements, reflecting the belief that SBHCs had to align themselves with mainstream health care. In addition, the report indicates that the key to a successful state strategy is in clarifying the public purpose of SBHCs, and that the basic models for SBHCs (medical home, public health, and an add-on model) reflect the centers' purposes. The report concludes by noting that the experiences of the nine states demonstrate a variety of efforts to secure access to existing public and private funding streams as well as generate state fiscal support for SBHCs. The onus is on the centers to prove their worth, a task requiring documentation of the number of children served, their insurance status, and services provided. This information is needed to lobby for inclusion in health plan networks, and for state or local revenues to cover the services often excluded from insurance coverage. (Three appendices contain the policy questions addressed by the states, list the meeting participants, and include the meeting agenda.) (KB)

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MAKING THE GRADE

STATE AND LOCAL PARTNERSHIPS TO ESTABLISH SCHOOL-BASED HEALTH CENTERS

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Nine State Strategies to Support School-Based Health Centers:

A Making the Grade Monograph

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October 1998

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Nine State Strategies to Support School-Based Health Centers

Executive Summary

A HISTORICAL PERSPECTIVE: A DECADE OF GROWTH AMID TURMOIL

Five years ago the Robert Wood Johnson Foundation launched a new national program, Making the Grade: State and Local Partners to Establish School-Based Health Centers, to support up to ten states in developing financial and other strategies to foster replication of school-based health centers. In June 1998, the Making the Grade states -- Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont -- came together to discuss the directions they had taken and the lessons they had learned. Moderating the conversation and reflecting on implications of various state strategies was Steve Rosenberg, the Program's long-time consultant on health care financing.

Initially replication strategies were planned around widely anticipated federal health care reform dollars and expanded state general funds. But within a year of Making the Grade grant awards, extraordinary change swept the health care and political environments. Grantee states were challenged to understand the changes, revamp their strategies, and, in many instances, re-tool their staffs and refine their political skills to pursue replication of the school-based health centers. In a world now dominated by market priorities, managed care, and conservative politics, most Making the Grade states pulled back from replication strategies that emphasized federal and state grant initiatives.

In 1993, when Making the Grade was announced, support for federal health care reform was strong and prospects for comprehensive health insurance legislation were good. A year and a half later, the Health Security Act was dead; the marketplace was ascendant, and government spending on health care was increasingly privatized, primarily through the spread of Medicaid managed care. In 1998, managed care's dominance in shaping the re-organization of health services was reinforced when most states chose to implement the new State Child Health Insurance Program (SCHIP) by directing those dollars through managed care delivery systems.

The collapse of federal health care reform and the conservative Republican electoral sweep in November 1994 transformed the political landscape in Washington and the state capitals. In both venues leaders came to power who resisted new public spending on health care and supported market solutions for health financing and services problems.[1] With the exception of Louisiana, Making the Grade states directed their attention to linking the centers to Medicaid managed care arrangements as part of a general strategy to increase funding through patient care revenues. Related to this third party revenue strategy was a broadly shared belief that school-based health centers had to align themselves with mainstream health care culture.

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[1] Passage of the federal State Child Health Insurance Program in August 1997 is a notable exception to legislative opposition to new health care funding.

Nine State Strategies to Support School-Based Health Centers

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To date, the dollar return on this strategy has been low, but alternative mechanisms for funding are unclear. Last year's passage of SCHIP greatly expanded public financing for children's health services. It also magnified the role of managed care in serving low-income children and thus heightened the need for school-based health centers to create or improve relationships with health plans. While all Making the Grade states except North Carolina are permitting SCHIP dollars to pay for services provided by school-based health centers, not all have fully linked the centers to the plans or figured out how they will finance the gap between third party reimbursements and total operating costs.

THE FUTURE CHALLENGE: DEFINING AND DOCUMENTING THE VALUE OF SCHOOL-BASED HEALTH CENTERS

The increased accountability demanded by managed care and the assumption that health plans have adequate provider networks to serve their beneficiaries has placed new pressures on school-based health centers to justify their existence. Making the Grade consultant Steve Rosenberg commented that the market is continually asking, "What are you and prove to us you have value in the marketplace." The key to a successful state strategy will be in clarifying the public purpose of the centers. He suggests that these purposes are reflected in three basic models for school-based health centers: a medical home model, a public health model, and an add-on model.

- Under a medical home model, school-based health centers are identified as providers of primary care and preventive services. Funding the centers is viewed as a mechanism for expanding the child health care delivery system. As a provider of non-duplicative care, the centers should receive a significant portion of their budget through patient care reimbursement.
- Under a public health or health care linking model (also referred to as an access model), a school-based health center is responsible for identifying and responding to the major health problems within the school community. A state strategy to support a public health vision of school-based health centers would understand that only a small portion of these activities will be supported through third party payments and would identify other sources of funding to support the public health mission.
- Finally, there are add-on programs. Essentially these are programs that may do good things but may duplicate others in the community. Add-on programs may also provide services that are not medically required, or for which there are no data demonstrating an impact on health outcomes. A peer counseling program organized by a health center might be one such service.

In theory, defining a model gives policymakers a clear sense of which streams of public moneys should support school-based health centers. In practice these three models oversimplify the course states have taken. In a number of states, the distinctions between the models are blurred and centers have multiple goals that vary sometimes by region of a state. It appears, however, that the prospects for long-term public funding for school-based health centers rests in no small part on states' ability to articulate why and how they are useful in the larger health care delivery system.

The nine Making the Grade states experienced the turbulence of the past five years in different ways and adjusted their replication strategies accordingly. Their funding plans and the issues they confronted are reported by each of the states in the paragraphs that

follow. The reflections of Steve Rosenberg on the strengths and weaknesses of the policy debates conclude the executive summary.

STATE STRATEGIES TO REPLICATE SCHOOL-BASED HEALTH CENTERS

VERMONT: BUILDING A STRATEGY ROOTED IN AN INSURED POPULATION

In Vermont where a small school-based health center program has been launched, the centers are viewed as advancing public health policy via the schools. To date, three centers have been established in rural communities. The centers are not expected to serve as medical homes but rather assure the provision of key physical and mental health services as well as preventive health services. Since 95 percent of the state's school-age children are insured *before* the State Child Health Insurance Program is implemented and the state is well supplied with pediatric and family practice physicians, state officials believe there will be no difficulty linking children to medical homes. One of the school-based health center roles will be to make sure all children have community-based primary care providers.

Because health centers will be fulfilling public health functions, it is not expected that they will receive significant patient care revenues. Instead, the basic state funding strategy focuses on using state-administered EPSDT dollars and dollars used to pay for "related health services" for special education students. The EPSDT dollars have been carved out of the Medicaid program to support a Medicaid claiming process which pays schools for providing administrative functions on behalf of the Medicaid program. Schools are also paid for providing comprehensive, preventive health services to Medicaid-enrolled students. The program, named the EPSDT School-Based Health Access Program, generates a million dollars a year. The state requires that if a school is going to participate in the Medicaid claiming program *and* seek a school-based health center, the school must direct 40 percent of funds generated by refinancing towards the school-based health center. Schools are also being reimbursed for health related services provided to Medicaid-insured students enrolled in special education. The state also obligates schools with school-based health centers to allocate 40 percent of their "related services" revenues to school-based health centers.

While the state is optimistic that the state-administered Medicaid dollars will provide a substantial portion of the support needed to sustain existing centers, securing funds for program expansion is a different challenge with which the state continues to grapple.

RHODE ISLAND: JUST GETTING STARTED

Drawing on the experience of its first four school-based health centers, Rhode Island began developing its statewide replication strategy a year ago. To date the state has not decided which school-based health center model it is implementing, rather it has focused on short-term financing issues, including helping centers find additional funds to cover operating costs not supported by the state grant and assisting grantees to maximize billing -- which means helping them in their relationships with managed care plans.

The first priority has been to assure that the centers are included in the managed care provider networks. When RIteCare, the state's two-year-old Medicaid managed care program, was launched, the RIteCare contract defined school-based health centers as essential community providers and required plans to contract with centers in their service areas. Translating this requirement into reimbursement to the centers for care

provided has been hard work. The managed care plans are concerned about health center quality and sometimes, probably for financial reasons, a child's primary care provider does not want to permit a child to receive service at the centers. However, the state has developed quality standards for the centers and implemented a Continuous Quality Improvement program as a way to encourage managed care cooperation. Four of the five managed care plans have signed contracts with the school-based health centers and some, though limited, RIteCare dollars are accruing to the centers.

Although the state is still early in its formulation of financing strategies, data from the centers indicate that even with a generous child health insurance program, the state will have to identify, at a minimum, $750,000 per year to help fund the 20 school-based health centers the state hopes to establish in all middle and high schools in five core Rhode Island urban areas. Negotiating the relationships between health plans and the centers and securing long-term state funding are the twin challenges the Rhode Island financing strategy faces.

OREGON: NEGOTIATING A LOCALLY-DRIVEN STRATEGY

Oregon sees school-based health centers as primarily fulfilling a public health mission, with the localities rather than the state defining what the public health priorities are. However, state support for an emphasis on preventive services is reinforced by data from its Office of Medical Assistance Programs that documented that *for young people ages 14-19 enrolled in the Oregon Health Plan for Fiscal Year 1996, only five percent had seen their primary care provider for a preventive health service.* Supporting expanded use of preventive care is a key component of state interest in school-based health centers.

The state's approach to replicating school-based health centers is to pursue a community designed and financed model that draws on technical assistance and limited funding from the state as well as benefits from a supportive statewide policy environment. Future funding of school-based health centers may look something like this: The state will provide partial support to all school-based health centers; a typical grantee might receive 30 percent of its operating budget. State participation not only will guarantee part of the core budget but will also serve as a mechanism for accountability. Third-party reimbursement and/or support from the sponsoring agency will total about 30 percent; the county will contribute 10 percent as will private donors such as business partners, and the schools will be expected to provide 20 percent of operating costs.

Oregon does not require that managed care plans contract with school-based health centers and the centers have faced significant difficulty in negotiating contracts with the plans. However, the state has submitted a request to HCFA that would permit the state to use a larger portion of the SCHIP dollars to directly fund safety net providers. With the state controlling more of the SCHIP funds, the state could expand support to those providers caring for SCHIP enrollees.

Oregon, like Vermont, is a state with a large proportion of insured children -- at least 92 percent. While the state continues to broaden its insurance coverage for children and adolescents, focus is turning to delivery system issues. Increasingly the mantra is heard that insurance alone does not assure that care is delivered.

The Oregon replication strategy requires that school-based health centers engage a number of partners to establish a sufficient funding base. The state notes that their experience demonstrates that the strategy can work. During the past six years the

number of centers has more than doubled, growing from 18 to 39 -- with additional new centers scheduled to open in the current school year.

NORTH CAROLINA: INCREASING ACCESS TO CARE THROUGH SCHOOL-BASED HEALTH CENTERS

North Carolina has also doubled the number of its school-based health centers, growing from 20 to 40 over the past five years. In this large state with 100 counties, there are substantial areas that are medically underserved. In some low-income areas, as many as 25 percent of children are uninsured. And in North Carolina as in Oregon, even insured children face barriers to care. For example, less than 20 percent of adolescents enrolled in Medicaid have received the comprehensive primary care services available through EPSDT. For these reasons, the state is supporting school-based health centers as a way of increasing low-income and uninsured students' access to care and assuring that preventive care is provided.

Financing strategies are based on (1) building financial linkages between school-based health centers and managed care arrangements as well as other third party payers, (2) partnering with private foundations, and (3) increasing state funding.

The Medicaid managed care program, a mostly primary care case management program, is called Carolina Access. Participating physicians are paid fee-for-service with the primary care physicians receiving an administrative fee for their gate-keeping activities. Only one county, the largest -- Mecklenberg County (Charlotte) - has a capitated program. The state Office of Medical Assistance, private providers, and the Health Department School Health Office have joined together to develop standards for school-based health centers. Centers that meet standards will not have to receive prior approval to bill Medicaid for the services provided. Two standards have already resulted from these discussions include: 1) at least 80 percent of all students enrolled in the school-based health centers should have an age-appropriate well-care visit, and 2) all enrolled students should have a well-care visit within one year of enrolling.

The SCHIP legislation, which was expected to supplement the Medicaid portion of the centers' patient care revenue stream, has excluded school-based health centers from participation. Despite intense lobbying by representatives of communities with school-based health centers, at least for this first year, the North Carolina SCHIP will not reimburse centers for care provided to its enrollees.

A second financial strategy to support the centers has been to work collaboratively with foundations. The largest foundation in the state, The Duke Endowment, and several others are providing seed dollars for planning and start-up for both school-based and school-linked programs as well as supporting traditional school health services.

A third and final strategy is to increase state funding for school-based health centers for the first time since its initial funding in 1991. The state hopes to do this both through the Maternal and Child Health block grant dollars and through an increase in funding for the adolescent health initiative in the budget for the next biennium.

NEW YORK: RE-TOOLING A 20-YEAR OLD PROGRAM TO SUPPORT SCHOOL-BASED HEALTH CENTERS

With 159 centers, New York has the largest school-based health center program in the country. To receive state funding these centers must meet standards that emphasize the provision of comprehensive services and, in partnership with its sponsoring institution, the capacity to serve as a medical home. The standards also indicate that the centers are

intended to serve public health functions, including provision of health education and preventive care.[2]

At present the school-based health centers receive $10 million in state grant funds (including general fund, Maternal and Child Health Block Grant, and Making the Grade dollars); and $6 million in Medicaid fee-for-service revenues. Centers are also supported with approximately $6.3 million in in-kind contributions by sponsoring institutions. This financing strategy for school-based health centers, however, is now in transition.

New York is committed to financing indigent health care through managed care and this means that the state is also committed to integrating school-based health centers into Medicaid and SCHIP managed care programs. For the past two years the state has granted the centers a temporary carve-out from its mandatory Medicaid managed care program . It was expected that the centers would use this time to negotiate contracts with the plans. The carve-out is expected to end shortly. Due to delays and difficulties in negotiations, the contract deadline has been postponed twice. Recently it was postponed again from October 1 until at least December 31,1998.

In New York the centers have been reimbursed at the hospital outpatient rate, sometimes up to $70 per visit -- which accounts for the $6 million in Medicaid revenues. Managed care plans are refusing to pay that rate, which has created a stand-off between the plans and the school-based health centers. The centers contend that they cannot survive the reduction in Medicaid payments; the state argues that the reduction will be offset by an increase in coverage for uninsured children through Child Health Plus (the New York SCHIP). The plans maintain that they will not pay $70 a visit and do not need the centers to offer an adequate provider network. Both parties have been unyielding. A great deal of work remains to be done to resolve the competing claims of school-based health centers and managed care plans.

MARYLAND: ADJUSTING TO CHANGED POLICY ASSUMPTIONS

When Maryland became involved in Making the Grade, its vision for school-based health centers was based on a devolution strategy called the Systems Reform Initiative (SRI) which was intended to support greater local control of state dollars spent at the community level. Given the local control aspects of devolution, the state did not articulate its own mission for school-based health centers. Under devolution, at the state level categorical dollars would be pooled and those funds would be distributed to the 24 Maryland local jurisdictions. These jurisdictions would make funding decisions based on the needs of their communities. The state believed local communities would see school-based health centers as an answer to some community needs. With the state already supporting school-based health centers with generous fee-for-service Medicaid reimbursement that covered mental health as well as physical health services, the assumption was that together these resources would provide basic funding for the centers when combined with in-kind contributions from the school system and grants for special activities. Both the SRI and Medicaid funding strategies have since unraveled.

Implementation of the Systems Reform Initiative has been a slow process with delays in amassing the required "savings" for investment in the program as well as difficulties in putting the administrative structure in place. Thus the Systems

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[2] Guidelines for School-Based Health Centers in New York, New York State Department of Health, 1996. Document can be located at www.gwu.edu/~mtg, State resources: New York.

Reform Initiative is no longer seen as a major funding source and the state has begun to re-engineer its financing vision.

The other pillar of Maryland's funding strategy, its generous fee-for-service Medicaid strategy, collapsed a year ago when HealthChoice, the Medicaid managed care program, was implemented. Managed care plans participating in HealthChoice are required to reimburse the centers for up to four acute care visits per semester with one follow up per acute visit. But to receive payment for any services, the school-based health centers must negotiate contracts with each participating plan. To date no contracts have been signed. The lack of success in contracting under HealthChoice is significant because the Maryland SCHIP program has been folded into HealthChoice. While schools have been identified as a place for SCHIP enrollment, no special funds from the "ten percent" dollars will be available to support direct service delivery.

A significant shift from the original financing vision is the greater role for private partners. Initially the state focused almost exclusively on public funding and public policy setting. Recently, private entities, especially large health care systems, have expressed interest in the school-based health centers. One of these systems is now subsidizing two school-based health centers. The state plans to nurture this development as an alternative model for financing the centers.

Despite the bumpy road, five new centers opened this year bringing the Maryland total to forty-three. Part of the growth is due to the state's distribution of a $300,000 seed fund over the past two years and the new partnerships with private providers. The state's primary challenge will be to sustain these fledgling efforts. Ultimately the Health Department needs to develop a budget package to help support the centers. However, before it submits a request to the legislature, the department needs a solid year of billing in all the jurisdictions with school-based health centers to document the gap between third party revenues and the total operating cost of a center. The state is concerned, however, that the jurisdictions most effective at billing are covering only 30 percent of their budgets. The remaining costs are supported by a mix of local support, grants, and in-kind contributions.

LOUISIANA: BUILDING A STATE-SUPPORTED NETWORK OF SERVICES FOR SCHOOL-AGE CHILDREN.
Funding for school-based health centers is solidly based on line item support in the state budget. Louisiana's original financing strategy involved Medicaid reimbursement, pooled funding, use of block grants, a local match and some state funds. In the first few years the state even spent time on Medicaid managed care. But Louisiana is still not doing anything with managed care and what the state has learned over time is that its best finance strategy is a political one. School-based health centers work with their legislators who become advocates for funding more centers. As a result Louisiana has an annual state appropriation of $3.25 million to support school-based health centers. And this is added to a Maternal and Child Health Block Grant allocation of between $600,000 and $1 million annually plus Making the Grade funds and local match contributions.

The policy has worked: the number of school-based health center sites has increased from four in 1991 to 30 in 1998. About 60 to 65 percent of each site's budget is derived from state resources. Local match is running between 30 and 35 percent; Medicaid revenue is only about three percent despite the fact that about a third of the centers' population is Medicaid eligible. Like North Carolina, the state views its centers as meeting public health objectives -- assuring access to preventive care and

addressing the primary problems of the population being served. If they have adequate weekend and after-hours back-up from their sponsoring institution, the centers may also serve some patients as their medical home.

School-based health centers did well during the SCHIP hearings in Louisiana. Everyone who testified before the Governor's commissioner, whether they represented a university or a provider group, included school-based health centers in their strategy. The centers are part of the delivery system in the state. With Medicaid being extended to kids up to age 18 and covered up to 133 percent of the federal poverty level (FPL) in year one of a three-year expansion to 200 percent FPL, the state anticipates a potential third-party payment turn-around. A worry is that maybe the students will not come to the centers when they have other options. Advocates don't think so but that remains to be seen. Customers will vote with their feet.

CONNECTICUT: RE-TOOLING AN ESTABLISHED STATE PROGRAM, PART II

Connecticut refers to its school-based health center program as having a multiple personality: the centers integrate medical, public health and social service models.

The state's financing strategy is based primarily on a grants program that funds 45 of the 51 school-based health centers in the state. The grants are supported by a state general appropriations budget of just under $4.5 million. An emerging second strategy is an increasing emphasis on patient care revenues. Like other states, the conversion of Medicaid to a managed care program has engaged the Health Department and the school-based health centers in efforts to link the centers to managed care plans. While it has taken two and a half years, nearly all the required contracts between school-based health centers and managed care are in place. The state Medicaid managed care Request for Proposals required plans to include school-based health centers in their networks, but the state learned that that was just the first step. Intense negotiation among the plans, school-based health centers, the Medicaid Office and the Health Department was essential to secure those contracts. Now the state has launched its SCHIP program, HUSKY (Health Care for Uninsured Children and Youth), a non-Medicaid insurance product with a more limited service package than Medicaid that requires co-pays. The state must now take the lead in a second round of negotiations to assure that the new HUSKY contracts are concluded.[3]

Despite success in the contracting process, the revenues generated as a result have ranged from a negative ten percent due to the cost of billing up to a positive ten percent (of operating costs). Most health centers are realizing five percent of their operating costs or less. Currently most sites receive between 60-65 percent of their budget from the state and 30 - 35 percent from local resources. Medicaid revenues average three percent.

Although revenue returns are disappointing, other benefits are emerging. Oxford Health Plan contributed health education materials for an asthma support program through a school-based health center in Stamford. The state is also discussing with HealthRight, another Medicaid managed care plan, the possibility of an EPSDT project in New London and Groton. EPSDT compliance in Connecticut has historically been low, particularly for adolescents. Under this arrangement HealthRight will utilize its outreach workers who do home visiting to inform parents about EPSDT. If the children are not

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[3] For an extended discussion of the State Child Health Insurance Program and School-Based Health Centers, see Jane Koppelman and Julia Graham Lear, "The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?," on the Making the Grade web site, www.gwu.edu/~mtg.

already enrolled in the local school-based health center, the outreach worker will enroll them. HealthRight will provide the school-based health center with a monthly list of its enrollees who need an EPSDT exam. The school-based health centers will provide the service and the plans will pay the centers.

The Connecticut legislature created an oversight council to track the implementation of Medicaid managed care. School-based health centers have a number of supporters on that council who are concerned about managed care's impact on safety net providers. The council has played an advocacy role to make sure school-based health centers do not fall through the cracks during managed care implementation.

A debate occurring within the Health Department is whether the recent infusion of money for child health insurance will make the state investment in the health care delivery system unnecessary. Among some legislators there is a feeling that with HUSKY, all kids have been covered so state support of a delivery system is unnecessary. The Health Department will have to gather data to respond to that concern.

COLORADO: SHAPING PRIORITIES IN A MARKET-ORIENTED ENVIRONMENT

Colorado's strategy to support school-based health centers has been strongly market-oriented, encouraging the health plans to use publicly-funded health insurance dollars -- both Medicaid and SCHIP -- to support the centers. To a lesser extent, the state is also attempting to identify dollars that can pay for uncovered costs. This strategy reflects a belief that at least in larger Colorado communities there are sufficient resources -- whether from a local hospital or school or foundation -- to support a significant portion of a school-based health center budget. Three pieces of legislation passed in 1997 provide a foundation for creating public revenue streams for the centers:

- Senate Bill 5 increases Medicaid managed care enrollment to 75 percent of Medicaid beneficiaries by the year 2000 and also defines school-based health centers as essential community providers (ECP). Managed care plans contracting with Medicaid are encouraged to make good faith efforts to contract with ECPs that provide services in their service areas;
- Child Health Plan Plus (the Colorado SCHIP) implements insurance expansion through a private model. It also uses the ECP definition of Senate Bill 5. Given the high rate of uninsured kids seen by many of the centers, with an increasing number of contracts in place between the plans and the health centers, CHP Plus has great potential to expand their third party revenue;
- Senate Bill 101, "Medicaid Reimbursement for Schools," authorizes participating school districts to become Medicaid providers. Thirty percent of the dollars recovered could be used by the schools to purchase health insurance for students or purchase primary care services directly for low income students. This means Colorado schools could use Medicaid to help support their school-based health centers. Unlike Vermont, however, the schools aren't required to do so.

Colorado also has some significant private initiatives. Kaiser School Connections is a dues subsidy program supported by Kaiser. Three school-based health center programs participate through 10 of their sites. The initiative basically represents a splitting of the primary care capitation -- with the school-based health centers receiving 60 percent of the cap, and 40 percent for Kaiser. Kaiser provides the medical supervision in collaboration with the school-based health centers. Another private initiative is with PacificCare in Denver. PacificCare provides a grant to participating school-based health

centers in return for HCFA 1500 billing data to build a utilization history as a basis for an on-going capitation arrangement with the school-based health centers.

Other financing comes from local in-kind support and private foundation participation. The state requires its grantees to secure substantial local contributions. These dollars provide a financial base, help fund mental health, and document community support.

Foundation dollars continue to be important. School-based health centers receive contributions from United Way, the recently-created Rose Foundation, HealthOne, Blue Cross/Blue Shield and others. Blue Cross will likely be privatized next year, resulting in the creation of a new, very large foundation. The hope is that this foundation will help support the centers as well.

A new contributor to state policy is the Colorado Association for School-based Health Care (CASBHC). This provider association includes nine of the twelve entities that sponsor school-based health centers. To facilitate contracting between school-based health centers and managed care, CASBHC has developed standards for three levels of certification for school-based health centers. The certification categories describe the service package for different types of school-based health centers without forcing them into a one-size-fits-all approach. Certification categories cover scope of services, physical plant, availability, quality assurance, and financing. Along with these categories, CASBHC has developed some quality assurance protocols and clinical outcome indicators that are based on HEDIS measures.

Documentation as the Bottom Line

The experiences of the nine Making the Grade states demonstrate a variety of efforts to secure access to existing public and private funding streams as well as generate state fiscal support for school-based health centers. At present, the onus appears to be on school-based health centers to prove their worth, a task which will require documentation of the numbers of children they are serving, their insurance status, and services provided to them. This information will provide evidence needed to lobby for inclusion in health plan networks, and for state or local revenues to cover those health promotion and education services that are often excluded from insurance coverage.

"Do not," urged Rosenberg, "confuse political support, which also is essential to secure public dollars, with whether you provide a necessary service. To those of you who currently enjoy strong political support but whose mission is less than clear, I can only urge you to make good use of this time to do the data gathering essential to document functions you are fulfilling."

Nine State Strategies to Support School-Based Health Centers

Five years ago the Robert Wood Johnson Foundation launched a new national program, Making the Grade: State and Local Partners to Establish School-Based Health Centers, to help up to ten states develop financial and other strategies to facilitate replication of these centers. In June 1998, the Making the Grade states -- Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont -- came together to discuss the directions they had taken and the lessons they had learned. Moderating the conversation and reflecting on implications of the various state strategies was Steve Rosenberg, the Program's long-time consultant on health care financing.

SETTING THE STAGE: A RAPIDLY CHANGING POLICY ENVIRONMENT

A MAKING THE GRADE PERSPECTIVE. That school-based health centers have grown rapidly during the 1990s and state agencies have continued to pursue strategies to promote their growth may reflect either extraordinary commitment to the centers' potential to reach young people in need or remarkable obtuseness about the impact of a volatile and challenging health policy environment. Whichever the case, it is a fact that during the past six years school-based health centers have increased almost four-fold, from about 300 in 1992/1993 to 1,154 in school year 1997/1998, with more than twenty state governments pursuing strategies to replicate school-based centers. And this commitment has persisted despite rapid change and instability in the health care environment.

Consider the following: In 1993 when Making the Grade was announced, support for federal health care reform was strong and prospects for President Clinton's Health Security Act were bright. Moreover, the proposed legislation included provisions dedicating substantial dollars for health services in schools. A year and a half later, the Health Security Act was dead; the marketplace was ascendant, and government spending on health care was on its way to privatization, primarily through the rapid spread of Medicaid managed care.

These events reverberated throughout the state agencies responsible for school-based health centers. In its first years, most states participating in Making the Grade had planned replication strategies around federal health care reform dollars and expanding state general fund commitments. By 1995, the collapse of federal reform efforts, the conservative Republican electoral sweep in November 1994, and accelerating opposition to government-sponsored programs in general spurred a search for alternative funding. As a result, with the exception of Louisiana, Making the Grade states mostly put plans to establish or increase state grant programs on hold and turned their attention to facilitating contracts between school-based health centers and Medicaid managed care plans. While the dollar return on that strategy has been low, the alternative mechanisms for public support, especially at the federal level, are unclear. Last year's passage of the State Child Health Insurance Program (SCHIP) greatly expanded public support of children's health services and brought school-based health centers another challenge. Sorting out the implications and opportunities of SCHIP has become the newest priority as the states continue to pursue the goal of stabilizing and replicating school-based health centers.

Nine State Strategies to Support School-Based Health Centers: A Making the Grade Monograph, The George Washington University School of Public Health & Health Services, Washington, DC.

A ROSENBERG PERSPECTIVE ON HISTORY .

When I first went on site visits to some school-based health centers in 1991, I kept scratching my head and saying, "What are these things?" And that is still the central question. Are they a medical home, a public health service, or an add-on service? And I think part of the challenge of a market-based strategy is that the market is continually asking, "What are you and prove to us that you add value in the marketplace?"

The state's answer to this question is fundamental to deciding what kinds of measures should be taken to support school-based health centers. And for purposes of this discussion, state policies should reflect support for one of three basic models for school-based health centers: a medical home model, a public health model or an add-on model.

- Under the medical home model, school-based health centers are identified as providers of primary care and preventive services. Funding the centers is perceived as a mechanism for expanding the child health care delivery system. Using this perspective, we would expect the state to vigorously pursue the inclusion of school-based health centers in Medicaid, the state's child health insurance program (SCHIP), and commercial insurance. To facilitate inclusion in the primary care networks, the state will make sure that school-based health centers meet standards for primary care providers.

- Under a public health or health care delivery linking model (also referred to as an access model), a school-based health center is responsible for population surveillance, that is, it identifies and responds to the major health problems within the school community; it identifies and responds to environmental issues that have an impact on health; it conducts prevention programs and it has a carefully considered health education program that articulates well with the health education curriculum implemented by educators in the school. The state strategy to support school-based health centers will understand that only a small portion of these activities will be supported through third party payments and will identify other sources of funding to support the public health mission. The state will also make certain that the centers are part of the state's re-framing of its public health mission and that they fit within the SCHIP. The SCHIP serves both a public health function, in that it supports outreach and enrollment of uninsured children, and a medical service delivery mechanism, in that it pays for service delivery.

- Finally, there are those programs we categorize as add-ons. Essentially these are programs that may do very good things but also may duplicate services or programs provided by others. Another definition of an add-on is that it is a service that is not medically required or one for which there is no data demonstrating a reduction in mortality or morbidity. A peer counseling program organized by a health center might be one such service. A state may choose to support school-based health centers as a means of intentionally providing redundancy in the system to assure that at-risk young people receive care, or the state may support services that are promising but not yet of proven worth. School-based health centers in this category will be vulnerable to funding cuts in tight economic times.

In other words, from our new, outcomes-oriented perspective in health care, a key question to ask of any state-supported health program is: Do you bring additional value to the health care system? If you do not, if your service is potentially duplicative, then your service is an add-on and it will face increasing difficulty in competing for *public* dollars.
States must identify a clear rationale for the centers. If the school-based health centers are not identified as part of an access strategy for unserved populations; not intended to

achieve specific, defined public health objectives; and not providing a new, essential component for the primary care delivery system, then the activities of a school-based health center may be identified as "add-ons," potentially of value but possibly duplicative, not essential for either public health or health service delivery purposes. And, therefore the centers have no assurance they will be funded with predictable, sustainable dollars.

NINE STATE APPROACHES TO SUPPORTING SCHOOL-BASED HEALTH CENTERS

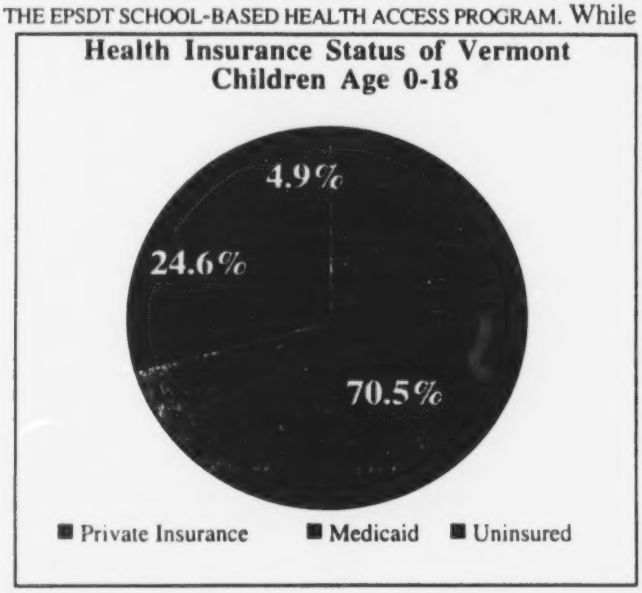
VERMONT: BUILDING A STRATEGY BASED ON AN INSURED POPULATION

SARA SIMPSON AND GARY SCHAEDEL:

The financing strategy

Vermont's funding strategy has been that, by the completion of its Robert Wood Johnson Foundation grant, school-based health centers would be drawing upon the Medicaid administrative claiming program that is available to most schools in the state and would be billing Medicaid and commercial insurers fee-for-service (FFS).[1] This strategy, which emphasized the role of patient care revenue, built on the exceptionally high rate of insured students in Vermont -- more than ninety-five percent with the SCHIP program yet to be implemented! While the introduction of Medicaid managed care has raised a question mark about patient care revenue projections, currently our school-based health centers are receiving FFS reimbursement from the health plans under the sponsors' contracts with the plans.

THE EPSDT SCHOOL-BASED HEALTH ACCESS PROGRAM. While early estimates suggested that patient care billing would cover most costs associated with the school-based health centers, Vermont intentionally linked the funding of the school-based health centers to participation in the EPSDT School-Based Health Access Program. This program helps schools draw down Medicaid Administrative funds. Funds are generated through the work associated with school nurses and



[1]The Medicaid administrative claiming program is based on federal regulations that permit federal support for state expenditures on outreach, follow-up, eligibility determination, and provider relations functions. See US DHHS. Medicaid and School Health: A technical assistance guide. HCFA, Baltimore, MD, August 1997.

guidance counselors to organize the delivery of medical services to children enrolled in Medicaid. The Vermont Department of Health is deemed the "EPSDT Medicaid Agency" and is empowered to contract with school districts in Vermont to provide EPSDT administrative services. Via contract between the Vermont Department of Health and school districts, EPSDT services can be provided and follow-up care arranged. To date 80 percent of the 60 school districts in Vermont participate in the program.[2] The Vermont Health Department contracts with the schools -- in essence, deputizing school nurses and school counselors to do some Medicaid administration for the state. The school earns money from Medicaid by billing for services provided. It is understood that once these moneys return to the schools they are to be used to advance the public's health and public health policy.

Given a state population of about 550,000, the EPSDT School-Based Health Access Program, which generates a million dollars a year, can make a big difference in Vermont. Several years ago the Health Department decided that if schools wanted to participate in the school-based health center program, they would have to participate in the EPSDT program. This year the state added that if a school is going to participate in the EPSDT program and seek a school-based health center, it must direct 40 percent of funds generated towards the school-based health center.

The schools have a similar arrangement with the State Department of Education. They are reimbursed for the health-related services identified in Individual Education Plans (IEPs) for students enrolled in special education. In May 1998, HCFA approved a change in the financing mechanism from a fee-for-service reimbursement system to a case rate system. Schools must allocate 40 percent of IEP-related revenues to the school-based health centers. Increased Medicaid eligibility (beginning October 1, eligibility will rise to 300 percent of the federal poverty level) and additional reimbursable services such as personal care aides will increase IEP-related revenues to schools. It is estimated that this program will generate up to $6 million annually.

State child health insurance program
The Vermont Office of Health Access has submitted a proposal to use Title XXI funds to increase coverage to underinsured as well as uninsured children in families with income up to 300 percent of the federal poverty level. The state anticipates funding this change whether or not the proposal is accepted.

The school-based health center model
When Vermont joined the Making the Grade initiative, it had no school-based health centers. The state was interested in developing its model as a way of expanding the health-promoting capacity of both practitioners in the community and existing public health services. As a result, our model links the school-based health centers to both the school nurses and their public health function as well as to the private physicians. Thus, the three school-based health centers in Vermont are not medical homes but rather are connected to primary care providers (PCP). If a child enrolling in the center does not have a PCP, the center will assist the family in identifying one and the school-based health center will notify the PCP of services at the center.

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[2] A relevant fact from history is that in the middle seventies the Vermont Medicaid program was sued for doing a particularly bad job of delivering EPSDT services. As part of the settlement, responsibility for EPSDT administration was moved to the Health Department.

An array of services is provided at the centers including routine preventive and episodic physical health care, mental health and substance abuse counseling, health supervision and education, and in some places, dental heath screening, referral and outreach. School-based health centers work closely with school nurses. This includes sharing space and in some cases the school nurse is also the school-based health center coordinator.

In a nutshell, Vermont characterizes its school-based health center efforts as advancing public health policy via the schools through collaboration among the Departments of Human Services, Education and Health, and the school districts, using the Medicaid administrative match dollars available to the state. We anticipate that this approach will generate dollars essential to sustain the centers. We continue to explore avenues necessary to support replication of the centers.

ROSENBERG COMMENTARY

Vermont carved out EPSDT from its Medicaid managed care program. In retaining the EPSDT dollars, the state was able to use those dollars for a public health function. Vermont has defined school-based health centers as a public health service that is being financed through retained EPSDT administrative money that did not go to private managed care organizations. Additionally, the centers are being encouraged to do fee-for service billing for those patients for whom there is a documented ICD-9 code for a visit. In essence, Vermont has developed a hybrid model that begins with a state public policy premise that school-based health centers are entities that advance the public's health, that in the course of fulfilling their public health role, the centers also provide some services that are billable under Title XIX or commercial insurance and an additional state policy is to encourage the health centers to bill for the Title XIX or commercial insurance. However, my sense is that the school-based health centers are not medical homes. The state developed a public health vision for the centers and the financing strategy reflects that vision.

Let me talk a little about why Vermont is able to pursue this policy. First, the state has a popular governor who is able to use his personal popularity on behalf of an investment in public health rather than succumb to pressure to shift all Medicaid dollars to the private sector. Second, Medicaid managed care in Vermont has had many false starts. By the time the managed care organizations came to the public policy table, the state had already intimidated the managed care organizations by threatening to go out of state to secure Medicaid contractors. This gave the state more power in its negotiations with the plans and reduced the capacity of the plans to insist on receiving all non-nursing home Medicaid dollars. These two factors enabled the state to retain some Medicaid dollars for public purposes with little resulting political heat.

RHODE ISLAND: JUST GETTING STARTED

ROSEMARY REILLY-CHAMMAT:

Rhode Island began implementing its school-based health center initiative one year ago and is just beginning to articulate a vision of what school-based health centers can or should be. With four school-based health centers up and running, no one model has yet been decided upon. To date we have focused on short-term financing

issues, that is, identifying funds to support school-based health centers, helping the centers secure those funds and assisting grantees to maximize billings. Billing alone will not be sufficient to cover costs and we know that additional dollars will be necessary and most likely they will have to come from the state.

The financing strategy
We have put initial pieces of a financing strategy in place. For example, the state Medicaid managed care program, RIteCare, has defined school-based health centers as essential community providers and required plans to contract with centers in their service areas. Four of the five HMOs have contracts with school-based health centers or their sponsoring institutions.

Of concern is the fact that limited patient care revenues have been reported by the school-based health centers. Thus far, the centers are collecting 20 percent of what they are billing the plans. Because it is early in the process, we are still attempting to understand what services have been billed for and why the collections are so low. School-based health center contracts with HMOs cover provision of medical services, mental helath and substance abuse services, limited family planning services, prescription drugs, limited laboratory services in accordance with CLIA regulations, and preventive care, including EPSDT examinations. However, the way these services are reimbursed varies according to the contract between the HMO and the school-based health center's sponsoring organization. We hope to have better data on these arrangements and the resulting dollar flows during the coming year.

There have been other implementation issues. For example, some community providers, which are the students' medical homes, will not give permission for their patients to be seen at the school-based health center. Sometimes the centers do not call because they know particular physicians will not approve a visit and do not document the refusals because that process is burdensome -- even though we need the information as background to recommend policy changes. So the State Program Office (SPO) is working with Department of Human Services, which is responsible for RIteCare, and with the health plans to modify the refusal-documentation process.

Another issue with the health plans has been around the issue of quality. Plans have queried whether the centers are quality providers. Recently the state pulled together information on how it oversees the centers and what kind of federal regulations apply and sent this information to the plans. Additionally, in early June, the SPO facilitated a meeting between representatives of the school-based health centers and the health plans at which the school-based health centers presented information on their sponsors' quality improvement measures and how those standards are applied at the sponsoring institutions and at the school-based health centers. The plans seemed impressed with the emphasis on standards and quality improvement and concerns among the plans seem to have abated. We have now formed a smaller working group to look at financing options. Recommendations from that group will be brought back to a larger group of representatives from health plans and school-based health centers. At that time we will determine ways to broaden the finance discussion to include other stakeholders.

We require that school-based health centers provide around-the-clock care which means that they must be closely linked to their sponsor organization. To participate

in RIteCare, they must provide a wide array of comprehensive services or access to those services through the parent health center.

State leadership
The Rhode Island State Program Office of Making the Grade is a partnership between the Department of Health and the Rhode Island Public Health Foundation (PHF). PHF has expertise in policy development and financing. Together we have concluded that even with a generous child health insurance program through RIteCare, the Rhode Island Medicaid managed care program, the state will have to identify, at a minimum, $750,000 per year to help fund school-based health centers if we are to establish them in all 20 middle and high schools in our five core urban areas.

To assist the state and school-based health center sites to plan for long-term funding, the SPO is developing a financial forecasting tool. The tool will use information on the insurance status of students attending targeted schools as well as information on the specific plans to which students belong to forecast third party revenue streams.

The SPO has also established guidelines for developing and maintaining the centers. We have standardized a data collection form. School-based health center network members collaborated with our office on these projects. We track how many visits, what they are for, as well as billings and collections.

State Child Health Insurance Program
In Rhode Island, SCHIP is helping us move toward universal coverage for children. Rhode Island will use the new dollars to expand RIteCare. The goal is to expand coverage for children and youth up to 300 percent FPL. We are talking about developing aggressive outreach strategies because we know that although RIteCare now covers children in families with incomes up to 250 percent FPL, we still have 1400 uninsured kids who are eligible for RIteCare. The Department of Human Services, which administers RIteCare and SCHIP, has allocated $800,000 to spend on outreach and they have organized a working group to develop outreach strategies. The SPO participates in these SCHIP discussions.

School health services and school-based health centers.
As far as linkages between school-based health centers and school health services go, our guidelines describe everything -- how you start a center, what policies you must implement, and how to coordinate with school staff, as well as community-based services and providers.

Reinventing public health.
Concerning the relationship of school-based health centers to public health re-organization, the Rhode Island Health Department has not provided direct services since the late 1980s. Since that time, public health agendas have been pursued through contracting with community-based entities, frequently the community health centers that sponsor all but one of our school-based health centers.

ROSENBERG COMMENTARY
Rosemary, here's what I heard you say. In Rhode Island, school-based health centers sort of serve a public health function and we indicated that by making them essential community providers. We haven't quite convinced the managed care plans that they aren't add-on services but we had a meeting with the plans on June 9 and we will

continue to work to convince the plans that they're not an add-on. In part we're doing that by documenting our efforts to take quality seriously. We are also requiring 24/7 coverage so there is the option for the centers to be a medical home but the problem is we're only getting 20 cents on the dollar from the plans when we try to put on that hat. What I heard you say is that you are still trying to be all three models. (Rosemary responded that Rhode Island has not answered that question yet.)

What I want Rhode Island and others to think about is that simply because you have a continuous quality improvement (CQI) process in place does not mean that you are not an add-on service. In your June 9 meeting you were able to show the health plans the extent of your state requirements and provide them some level of assurance as to the quality of care being offered. However, as you start looking beyond the CQI process, the burden of proof that you're not an add-on service rests with you in terms of how you think about organizing the centers.

Rhode Island has done a really good job of beginning the process of documentation, record-keeping and accountability. One of the premises of CQI is that accountability has to be built into the design of any service provided by either the government or a private entity because accountability is how you measure the continued improvement of your product or service. Because you've done a good job of building an accountability mindset, what you have is something that suggests that the CQI process and mindset is being put in place. That's very seductive to policy makers and health plans who assume that because you have a CQI program in place you are therefore building documentation as to cost-effectiveness and quality of your service. This does not necessarily follow. So when I said that you still have a burden to show that you're not an add-on service, I'm saying that because you have a CQI plan does not let you off of that responsibility. If your CQI isn't organized so that you are documenting cost-effectiveness, you will have a problem. What I want to urge you to do as you are setting standards and building accountability is to document the cost-effectiveness of what you are doing -- because that is what will help you resolve the question of whether you are an unnecessary add-on.

OREGON: NEGOTIATING A LOCALLY-DRIVEN SCHOOL-BASED HEALTH CENTER STRATEGY

ROBERT NYSTROM:

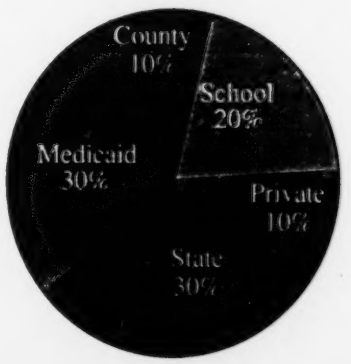
Oregon's basic strategy is a *locally determined approach* that is combined with technical assistance from the State Program Office as well as creation of a policy environment which will support the centers. The State Program Office, which coordinates these efforts, is located in the Oregon Health Division, a component of the Oregon Department of Human Resources.

Oregon sees school-based health centers as fulfilling a public health mission, with the localities rather than the state defining what the public health concerns are. However, state support for an emphasis on preventive services is reinforced by data from its Office of Medical Assistance Programs that documented that for young people ages 14-19 enrolled in the Oregon Health Plan for Fiscal Year 1996, only five percent had seen their primary care provider for a preventive health service. Supporting expanded use of preventive care is a key component of state interest in school-based health centers.

The financing strategy

LOCAL FUNDING MODELS. Oregon school-based health centers in 1998 are funded from a variety of different sources. One of the Making the Grade sites, in Jackson County, receives no direct state support beyond the RWJ grant dollars. The third party reimbursement component now makes up about 18 percent of the operating budget; the county government has made a small contribution and the school system has made a cash commitment. Two community hospitals are providing the remaining funds.

The budgets for the two other counties participating in Making the Grade look different because each community has different circumstances. In Multnomah County the county commissioners have funded school-based health centers generously for years and their ten school-based health centers are mostly supported by Multnomah County taxes. In Umatilla County, the presence of a very strong hospital has led to hospital-sponsored school-based health centers -- though their budgets are supported by multiple sources, similar to Jackson County.



Sources of Funding for SBHCs: A future revenue model for Oregon

In the future, all school-based health centers in Oregon will have some state funding. We are working now on moving towards this model. This state role will not only provide part of a guaranteed funding base but also will serve as a mechanism for accountability. Third party reimbursements and/or dollars from the sponsoring agency will be 30 percent, the county will be responsible for 10 percent of the budget, and the school represents 20 percent. Private contributions will be 10 percent -- mostly business partners of the school. The state piece is in position; the schools are working on the private contributions because each school has business partners. In Jackson County, the two school-based health centers have received a cash commitment from the county to support the centers from their general fund; the 30 percent of total budget figure represents the final agreement about what would be the most reasonable expectation both for third party payments and grants from managed care plans or other medical support.

MEDICAID REIMBURSEMENT. Reimbursement from Medicaid and commercial insurance remains a minor component -- usually less that 20 percent. We have had a 2-year demonstration with Medicaid where we can bill from all our Making the Grade demonstration sites using a unique provider number. It wraps up in December. This demonstration will enable us to establish a billing history with the Medicaid Office and at that point in time we will be addressing the harder policy questions: Will the state extend this reimbursement policy to other school-based health centers? Should the state consider this a type of carve-out? What would the true cost of such a policy be?

GRANT SUPPORT. Particularly good news is that while we have had state general fund support for many years, for the first time in many years the Health Division has recommended an increase in the line item that would support school-based health centers. This recommended increase was the third priority out of 22 budget priorities -- and that tells you how far up the ladder we have been able to move school-based health centers. We have a $2.6 million "add" piece for this part of the budget. When joined to current school-based health center funding, it would make possible 28 percent to 42

Nine State Strategies to Support School-Based Health Centers: A Making the Grade Monograph. The George Washington University School of Public Health & Health Services. Washington, DC.

percent for base funding for a typical school-based health center. We are feeling very good about the prospects for this request. In October we will know for sure if it survived to be incorporated into the Governor's budget.

State leadership
The Making the Grade State Program Office role in developing state policy has concentrated on staffing issues, data collection and analysis, and recommendations for state policies that affect school-based health centers. Increasingly the office has been included in important policy development, especially during this past year.

Policy effectiveness for local partners
Are we effective? I look back on the 1993 planning grant and at that point we had 18 school-based health centers; we currently have 39 school-based health centers and to a certain extent, the locals are out there doing it by themselves. We know of at least two new centers that will open in the 1998/99 school year; and a couple of other sites that are in a planning mode may open during this coming year as well.

But there have been mixed results at the local level. There are great differences in the amount of effort localities are willing to invest in long-term financial planning. It has been a struggle to convince communities that they have to put some energy into long-term planning. Sometimes they have waited until they've realized that some of their grant money is going away before they've seen the need to make this a priority.

Tax and revenue barriers are a nightmare in Oregon and create challenges for a local financing strategy. Long-standing tax limitation measures have capped the ability of locals to raise additional money -- whether for schools or other components of local government. An additional challenge is created by a double majority rule. The double majority rule says that even though a town may put a finance measure on the ballot and even though the majority of those voting support the measure, if a majority of voters did not turn out for the election, the measure fails.

Oregon's state strategy is in place but it has been slow to institutionalize. We have had to wait for two years for the Medicaid information; we wait every other year for opportunities to recommend policy changes to our legislature. But I think the strategy is maturing.

The comprehensive model
Does our strategy promote or limit the comprehensive model? The answer to that question is both. State core funding allows for some positive pressure because the state is taking a look at linking funding to a more comprehensive model. That position will get communities to look harder at things that they are and aren't doing. The state's promotion of quality standards and linkages to managed care has also had a positive affect on quality and treatment protocols. A possible negative effect has come from state pressure on health centers to obtain student insurance information and to negotiate reimbursement arrangements. No center budgeted for the staff to do that. We understand the larger value but its had a difficult impact on some of our projects. The other negative impact is the emphasis on reimbursement for a limited set of services which could come at the expense of preventative health, health education, psycho-social services and a very friendly atmosphere. We worry that the reimbursement structure will have a negative affect on the nature of school-based health centers as we've come to love them in our state.

School-based health center relationship to medical home

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One of the best things that has come out of activities around third party payers is improving relationships with school-based health centers and community-based medical homes -- in terms of communications, provider relationships, documentation. This has occurred in all our centers and has been the basis for beginning contracting between school-based health centers and managed care.

State child health insurance program
In terms of the Oregon SCHIP program, our office and local partners participated in the hearings conducted by the Oregon Health Council. The Council advised the governor on the content of the Oregon SCHIP application. School-based health centers are positioned in the application to HCFA as part of a future waiver that would enable the state to use Title XXI funds to build a network of safety net providers to work with SCHIP in providing direct health services to some children outside the traditional health insurance model.

Also relevant to the SCHIP is the recently implemented state-funded Family Insurance Assistance Program (FIAP). FIAP is an insurance subsidy program for families and SCHIP had to be laid on top of that. Oregon, like Vermont, has single digit uninsurance for children; possibly under 8 percent. While Oregon is talking about universal child health insurance, increasingly the mantra which is being heard is that insurance alone does not assure that care is delivered.

Reinventing public health.
Our public health structure has changed as we have moved aggressively into the Oregon Health Plan and moved toward managed care . We have local health departments that are still full primary care providers; we have others that have lost pieces of their primary care, especially in areas of mental health, and some that do none. There is a diverse environment out there and the Oregon state challenge is always to find a model that works in that diversity.

Oregon has a Turning Points grant from Robert Wood Johnson to help the state think through its public health strategies and school-based health centers will be part of that discussion, especially how to provide health services to certain adolescent populations.

School health services and school-based health centers
We have no statutory relationship between the two programs. There is guidance for school health services from the Department of Education but it is up to local communities to determine how they will implement the guidance, including making a decision they will not include school nurses in providing school health services. State law requires school districts to involve a school nurse in developing a health services plan, but school nurses are not required to implement the plan.

ROSENBERG COMMENTARY

I heard you say that you have been very successful in developing a public health model in which "public" is defined locally and your strategy has been to allow each of the localities to define how school-based health centers fit within public health, in the broadest sense of the term -- which is why I found your SCHIP strategy so interesting and in some ways is a measure of your success in taking that approach.

One of my personal difficulties with the public health approach to school-based health centers is that we built this concept that students take an active role in enrolling & that active enrollment is seen as the point at which they "contract" to be a participant in the school-

based health center. In the medical home model, enrollment becomes important because enrollment is crucial in Medicaid managed care. If I think about the add-on model, enrollment is how you document that you are being successful, that is, that the students are voting with their feet that you are providing add-on services that have value to them and you document the value by student enrollment in the center. If you think about a public health model, the issue of enrollment is a little more paradoxical. The public health model, after all, will focus at least in part on the entire school population. Moreover, if funding the center does not depend on third party payments, where is the incentive in a public health model of school-based health centers for developing maximum utilization?

I would suggest that one way to create an enrollment incentive is for the state to tell school-based health center grantees that to qualify for state dollars, they need to have 75 percent enrollment. You have to demonstrate that students are connecting with the model.

My message is that the public health model must be held accountable -- because you can have great school-based health centers, but if you don't touch kids, there is no basis for supporting the centers -- even though they allegedly serve a public health function.

NYSTROM: Since we will require local partners to implement a quality improvement tool as part of the process for securing base funding, we could include an enrollment requirement. Strategically, however, these requirements will have to be discussed in two policy and political settings: the State Coordinating Committee for School-Based Health Centers and the Conference of Local Health Officials.

SHAEDEL: Is there a threshold number that school-based health centers should reach? In Vermont it is still a new concept for the schools to be accountable, especially in health care.

ROSENBERG. This is true but what I heard Bob say is that third party payments are not worth the trouble of collecting them and the substitute I am suggesting, as a way of incentivizing effective performance, is to link state payments to performance. In the public health model, the fiduciary dependence may not be linked to third party payments but I want to recommend that a state standard or requirement is necessary.

LEAR. We might pause to consider the dichotomy between the accountability culture in managed care and the non-accountability culture in politics. Indeed, some would argue that the last thing most legislators want is some hard and fast rules that might cut against their favorite programs.

But school-based health centers cannot ignore the accountability culture and we will have to bring our colleagues along; we will have to find accommodations between political exigencies and performance realities.

ROSENBERG. The decision to go to a market-based health care system, even for publicly supported patient care, rests in part on the notion that the market will self-regulate with a little help from the government by having the consumer hold the market accountable by performance-based report cards.

HEDIS, the Health Plan Employer Data and Information Set, is now the gold standard for quality. HEDIS, developed first by the plans and commercial purchasers of managed care but then joined by the government to assure that HEDIS standards addressed the needs of

Medicaid beneficiaries, has become the universal standard for accountability. A number of states are holding their Medicaid managed care plans accountable for HEDIS standards.[3]

HEDIS standards are not a natural fit for public health. Historically public health has been viewed as something for which measurable outcome data was not possible because public health was political (in the big meaning of political) and the benefits were intuitive rather than documented. When you take a hybrid model like school-based health centers and start holding them accountable in the HEDIS sense, you may be documenting things that no one particularly wanted documented. So one of the perils as we move into the accountability era is that you will be careful in thinking through your state standards -- what are you asking for in terms of reporting and what are the political implications.

LEAR. Over the years our office has sensed that school-based health centers are sometimes undermanaged, that is, the centers do not have the structure required to handle most management responsibilities, not just documentation for accountability purposes. This is an area where the sponsors of school-based health centers have been let off the hook. One of the things we want to do is help grantees secure stronger sponsor support in the areas of human resources, quality oversight and fiscal management.

ROSENBERG. It's not just an issue of the sponsor responsibilities. The other issue that I want to get at has to do with the concept of the relationship between mass and outcome, that is, the larger the number of units over which you can spread overhead costs, the lower the cost of the administrative add-on. A challenge for the State Program Offices is to figure out how to apply the lessons of Henry Ford to school-based health centers.

A final point. If you are taking a public dollar, you have to be publicly accountable. It is not sufficient to say that we're good people and we do good things. This issue of accountability has to be addressed.

NORTH CAROLINA: INCREASING ACCESS TO CARE THROUGH SCHOOL-BASED HEALTH CENTERS

MARILYN ASAY:

We have doubled our school-based health centers in the past four or five years, growing from 20 to 40. We are a large state, 100 counties and the tenth largest state in terms of population. We have a strong public health system with a long history of working with county health departments across the state. The managed care market in the state is immature; most Medicaid managed care enrollees participate in a primary care case management (PCCM) system. About two-thirds of our counties are designated as partially or wholly underserved and estimates indicate that 13 to 16 percent of school-age children are uninsured. In many of the low-income areas as many as 25 percent of the children are uninsured. There are barriers to care even for Medicaid enrollees. Under 20 percent of adolescents enrolled in Medicaid have received EPSDT services. As a result we have been able to persuade the Office of Medical Assistance that having school-based health centers, especially in rural and underserved areas, would help them reach their EPSDT goals.

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[3] For a full description of HEDIS and school-based health centers, see the document "HEDIS 3.0: A Guide for SBHCs" on the Making the Grade website, www.gwu.edu/~mtg.

The financing strategy

Our state policy for school-based health centers is really about increasing low-income and uninsured students' access to care. We are developing our financing strategies in part around developing linkages with managed care and third party reimbursement, and continuing to expand the network of school-based health centers through a partnership between state funding and funding from several private foundations.

MEDICAID MANAGED CARE: A CASE MANAGEMENT APPROACH. Our Medicaid managed care program is called Carolina Access. Participating physicians are paid on a fee-for-service basis with the primary care physicians receiving an administrative fee for their gate-keeping activities. Carolina Access is now in 80 of the 100 counties and will be in all of them by the end of the year with the exception of the largest county, Mecklenberg County (Charlotte). This county has our one capitated program. Because the gatekeeper model was the managed care model we would be working with, we have spent time working with the Office of Medical Assistance and the private providers to put together an agreement. Just this week they agreed to have us work with them to develop a credentialing process of standards for the school-based health centers. Credentialed centers will not have to have prior approval to bill for the services provided. So far we have already agreed on two standards to be included in the credentialing criteria. These are: (1) at least 80 percent of all enrolled students should have an age-appropriate well-care visit, and (2) all enrolled students should have a well-care visit within one year of enrolling.

At the beginning of our discussions with physicians participating in the Carolina Access program, there were concerns about the primary care case management administrative fee. The physicians worried that centers would want to be the medical home and receive the administrative fee. We assured them that this was not the case. It was interesting that when we talked about using our standards for school-based health centers as a basis for credentialing the health centers to participate in Carolina Access, the physicians said that maybe we set the bar too high. Our response was that the centers really do have a focus on mental health services, nutrition counseling and health promotion, and that was important to us. So we decided to leave the credentialling criteria as we proposed. We know a number of centers are not comprehensive and we hope the credentialing process will push them to implement the model or they will decide not to participate in Carolina Access.

STATE CHILD HEALTH INSURANCE PROGRAM. Our SCHIP legislation, which we had expected to supplement the Medicaid portion of our patient care revenue stream, has not done well by school-based health centers. At the eleventh hour a provision was inserted that prohibited payment by SCHIP for services provided at school-based health centers. Despite intense lobbying by representatives of communities with school-based health centers, at least for this first year, the North Carolina SCHIP will not reimburse centers for care provided to its enrollees.

FOUNDATION PARTNERS. Our second financial strategy has been to work in partnership with foundations. We have been fortunate to partner with the largest foundation in the state, The Duke Endowment. Duke and several others are providing seed dollars for planning and start-up for both school-based and school-linked programs as well as providing support to traditional school health services. The state office's responsibility is to provide technical assistance to the communities and assure that they will be in compliance with our standards for school-based and school-linked services upon which state credentialling will be based.

STATE GRANT DOLLARS. Our final strategy is to work on increasing state funding for school-based health centers for the first time since its initial funding in 1991. We hope to do this

both through the MCH block grant dollars and through an increase in funding for the adolescent health initiative in the budget for the next biennium.

ROSENBERG COMMENTARY

In North Carolina you still see school-based health centers as an access program and the strategic issues around financing have been left largely on the backburner as you are encouraging the development of new centers as part of your drive to expand access. You've made the decision that the school-based health centers are not a medical home, but you want to generate a little third party revenue from the PCCM program concurrently so there is a small carve-out enabling centers to bill without pre-authorization under limited circumstances. And you can hardly be called an add-on service because you're in shortage areas providing a service.

I would like to identify several downstream concerns for you to think about:
One is that the state has done a really good job at keeping the privatization of health care for the poor at bay but you are likely to lose that battle over time because that's the way the market is moving. At the point you go through that process you are likely to find that the access issues that have been predominant in the state will change once the private sector has incentives to provide access. What happens to your access strategy if privatization happens? Where will school-based health centers fit? This means, for example, that the PCCM managed care approach will, as it has in other states, flip over to an 1115 or 1915(b) waiver strategy involving capitated contracts with large managed care plans. Where will school-based health centers be then?

ASAY. In connection with the effort to deny school-based health centers' participation in SCHIP, I also worry about the efforts to limit adolescents' access to confidential services. We see efforts to reduce adolescents' ability to seek services in areas critical to their health.

ROSENBERG. There really is a public policy divergence between saying we're not supportive of school-based health centers, and saying that we're not supportive of school-based health centers participating in the SCHIP program because we're moving to a market model and there is no role in the market place for these liberal programs. And at the same time the legislature is funding these programs and taking the cost out of the taxes of people who work for $8 per hour. Can those legislators defend support for those services? Can you justify school-based health centers as a good investment for their $8 per hour workers? And that's a really different question than whether we include it in the SCHIP benefit package.

ASAY. This is a very important point in North Carolina because at least seventy percent of all North Carolina mothers, both single and from two parent families, are working in low paying positions and these are the parents of children who use the centers. Advocates for the centers are trying to mobilize them and say this matters in the election in November.

NEW YORK: RE-TOOLING A 20-YEAR OLD PROGRAM TO SUPPORT SCHOOL-BASED HEALTH CENTERS

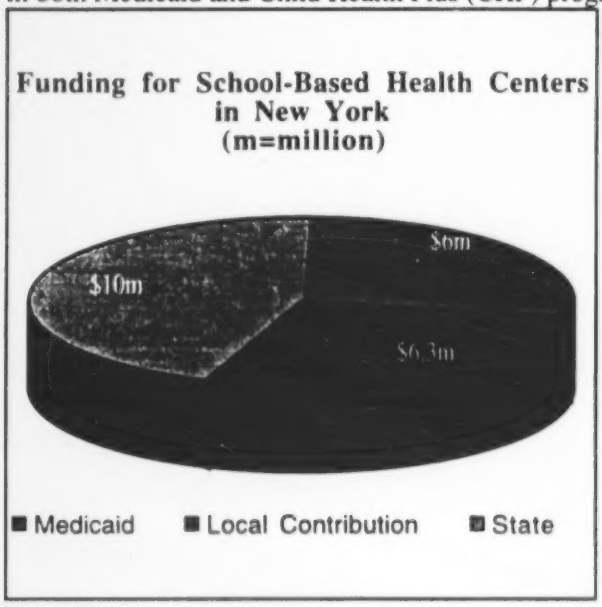
CLAIRE MALONE:

The financing strategy
The pie chart (see below) describes our funding set up for school-based health centers in

New York. It reflects a financing strategy that combines substantial grant funds, local contributions, and patient care revenues.

Currently we have $10 million in state funds that include Making the Grade and Maternal and Child Health Block Grant dollars; about $6 million in Medicaid revenues and about $6.3 million in in-kind contributions from sponsoring institutions. The State Department of Health is responsible for school-based health centers and the Medicaid program. That's a change from 1994 when it was the State Department of Social Services that housed Medicaid.

New York is committed to financing indigent health care through managed care; we're committed to integrating school-based health centers into managed care and involving them in both Medicaid and Child Health Plus (CHP) programs. To make this happen there must be contracts between the school-based health centers and managed care plans. We have told both the school-based health centers and managed care plans that contracts must be in place by October 1, 1998.[4]



We have about 29 percent voluntary enrollment in managed care in New York. We have an 1115 waiver and some 1915b waivers. Mandatory enrollment has begun in nine upstate counties. We are scheduled to begin mandatory enrollment in New York City by zip code in September. While one part of Brooklyn has moved into Medicaid managed care under a 1915b waiver over the past several years, moving the entire city into mandatory managed care over a two-year period will be a challenge.

How will this affect the school-based health centers? They have been billing fee-for-service Medicaid for a number of years. Since 1993, the centers billed Medicaid under their sponsoring institution's outpatient rate. When Medicaid managed care began to be implemented on a pilot basis, we did a temporary carve-out for school-based health centers but told them they would have to negotiate contracts with the plans within two years. The carve-out will end on October 1.

There are many barriers to contracting and the results are few. The logistics alone are staggering. The 158 school-based health centers have 60 institutional sponsors. Thirty-seven managed care plans operate in the state. Ninety-nine of the school-based health centers and 25 managed care plans are operating in New York City. If you multiply these numbers, that is, 25 by 99, you can see the magnitude of the problem in New York City alone.

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[4] In late summer the Governor's office announced that the carve-out for school-based health centers in New York would be extended at least until Decemer 31, 1998.

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Mobility of the children is an additional challenge, especially at the middle and high school levels which have open enrollment. Children frequently travel across the city to attend school. They may enroll in a plan in the Bronx but attend a school in Manhattan and the plan doesn't serve Manhattan.

Identification of the insurance status of children has also been a substantial problem. And there isn't incentive for families to provide insurance information because the school-based health centers must serve all children as a condition of receiving state grant funds.

And there are other managed care issues. Will the school-based health centers provide primary care? urgent care? mental health services? The answer to Steve's question about "What are you?" differs depending on whom you ask. The school-based health centers say, "Yes, we are a medical home," The plans say, "No, you're an add-on service" and the state can't decide whether they are public health or managed care.

In New York the centers have been receiving a generous hospital outpatient rate, sometimes up to $70 per visit. Managed care plans are not going to pay that amount of money. And this has created the real stand-off in negotiations between the plans and the school-based health centers.

We are in transition in this arena. A few contracts are in place but the major plans and large school-based health center networks have not linked their efforts. The Commissioner is committed to integrating school-based health centers into managed care. She believes that increased participation rates in Child Health Plus thanks to the SCHIP initiative as well as a broadening in Medicaid eligibility will increase the flow of dollars to the centers and should, with state grant support, enable them to participate in the managed care provider network.

ROSENBERG COMMENTARY

Here's what I heard you say. You have a Republican governor and an enlightened Commissioner who are trying to move school-based health centers into a market-based model of managed care. The only problem is that centers have done well under previous reimbursement arrangements. Trying to figure out how to make that jump to a market-based environment has been a challenge.

The upcoming October date represents the second time the Commissioner has set a date for requiring reimbursement for Medicaid and CHP through the managed care plans, and this particular date is a month before the election. And with the governor running for re-election this date may have some flexibility.

Let me talk about some of the structural dangers of what New York has done. We're in this dilemma in New York City because school-based health centers were identified as access programs. They were financed through grants and through a generous reimbursement program because the state said there were serious access problems in the underserved areas where school-based health centers were located and thus it was essential to make more services available.

Then the Republicans came in and are trying to move to a market approach. The market is saying to the centers: "We don't need you. We're perfectly capable of providing access points to kids in need and we don't need school-based health centers as an access point."

The state policy people are saying "Well, maybe you do, and until we know, let's make you contract with them as an access point." I would say that New York is avoiding the essential policy issue. And the essential policy issue is: will these entities be needed as access points in 1999 or not. If they are needed as access points, then the state's policy becomes clear: they should be funded with sufficient dollars so that they can keep their doors open as access points. And if we are privatizing those dollars through Medicaid managed care organizations, then we need to figure out how to transfer those dollars from managed care to the school-based health centers.

The dilemma is that there are no viable data on which the state can stand up and say "We need these as access points." There is only a political infrastructure of folks who are committed to the school-based health centers and who are effective advocates of the position, "we are an access point." And North Carolina needs to learn from the New York dilemma because North Carolina is building an infrastructure that could face the same problem as New York should massive privatization of Medicaid move south.

One of the essential challenges for school-based health centers is "How do you document that you are a critical access point?" Absent being able to prove this, how do we know that the plans aren't correct when they say we don't need these entities. State, if you're going to force me to contract, I want a contract with them on whatever minuscule terms I can manage, because I do not need them as part of my provider network. If you want me to go out and manage care in the marketplace, let me do it and don't micromanage me and tell me who to contract with and how to pay.

And this is a fascinating discussion because the state has consistently avoided addressing the issue of whether they are truly access points. And we don't know the answer to that question.

LEAR. Given that managed care plans are contracting mostly for physical care and school-based health centers provide a broader range of services -- from health education to mental health to physical health -- I'm surprised no one is putting that into the mix. Has the state considered school-based health centers as a public health model?

MALONE. Yes, but it is one of the debates that goes on and on. Public health is also changing because of managed care -- it is a difficult and challenging question.

ROSENBERG. That's the public health piece. The state hasn't stopped giving them grants so that grant program can be provided for a subsidy to provide those other things. The question on the table is, for those acute physical health services that we can code for an ICD-9, should we force the plans to contract with school-based health centers? Isn't this a good time to see whether plans can do this as measured by outcomes compared with plans we force to contract with school-based health centers?

LEAR. This discussion ignores the fact that the strongest school-based health centers which provide not only physical health services but mental health and substance abuse as well help pay for those services via the their reimbursed physical services -- and the minute we eliminate that source of up to 30 percent of their budget, they will not be able to maintain staff to provide the preventive services and programs.

MALONE. We are also looking at the requirement that school-based health centers respond to the needs of everyone who comes in the door. Are there health care needs where a school nurse would be a better, more cost efficient solution than a school-based health center?

ROSENBERG. Cost reimbursement is a wonderful thing. As long as we keep cost-reimbursing these programs, we never ask these questions. It's only when you stop cost reimbursing do these questions get raised and you can go out and do the demonstrations that get to some of these issues. One of the perils of access programs is that you build a program that assumes that this stuff works without testing the assumption. One way states might do that would be to review data on where Medicaid beneficiaries are getting their care by zip code of residence and by provider ID. That would allow you to show whether the Medicaid beneficiaries are dependent upon the school-based health centers for basic services. You could compare communities that have school-based health centers and those that do not and you could compare utilization, communicable diseases, etc.

MARYLAND: ADJUSTING TO CHANGED POLICY ASSUMPTIONS

DONNA BEHRENS:

Financing strategies.

IN THE BEGINNING. When Maryland first became involved in Making the Grade, it had a vision but not exactly a funding strategy for school-based health centers. This vision was based on a broader devolution strategy called the Systems Reform Initiative (SRI) which was intended to support greater local control of state dollars spent at the community level. At the state level, categorical dollars would be pooled and those funds would be distributed to the 24 Maryland local jurisdictions (23 counties plus Baltimore city). These jurisdictions would then make funding decisions based on the needs of their communities. We believed the local communities would see school-based health centers as an answer to a number of community needs, thus they would use their funds to support the centers.

The state was already supporting school-based health centers with a generous fee-for-service Medicaid reimbursement strategy that covered mental health as well as physical health services. The intent was to join local community funding under SRI with a supportive state Medicaid reimbursement system. Together these resources would provide basic funding for the centers when combined with in-kind contributions from the school system and grants for special activities. This vision for financing the school-based health centers seemed quite reasonable.

A BUMPY ROAD. Implementing the Systems Reform Initiative required each of the 24 jurisdictions to develop their own Local Management Board (LMB) to oversee this process. The source of pooled funds for the local jurisdictions was to be dollars saved by reducing or eliminating out-of-home and out-of-state placements for children. By returning kids to communities and providing community-based care, it was anticipated that the costs of caring for these children would be reduced and the savings would free up dollars for the pooled fund. We learned, as the program was implemented, that these communities did not have systems in place to care for the children and the cost of building an infrastructure for community-based care absorbed most of the anticipated savings. Moreover, the politics of creating a new entity such as the Local Management Board with real dollars to spend and real political power was not a mere technical matter. Today, our 24 Local Management Boards are in various stages of development. In some jurisdictions, LMB development is still in its infancy. Currently no LMB directly supports school-based health centers in Maryland. So, Maryland has had to re-engineer its financing

vision and develop alternative strategies. The following paragraphs outline the basics of our new approach.

MEDICAID MANAGED CARE. Like many other states, our fee-for-service Medicaid strategy to support school-based health centers became obsolete a year ago when HealthChoice, our 1115 waiver program, was implemented. Currently, school-based health centers are participating in HealthChoice on a limited basis. Managed care plans participating in HealthChoice are required to reimburse the centers for up to four acute care visits per semester with one follow up per acute visit. While this arrangement has the benefit of allowing self-referral and by-passing pre-authorization, it limits the capacity of centers to treat chronically ill children because follow-up visits are limited. The legislation provides no parallel automatic reimbursement for comprehensive primary health care. To receive payment for any services, the school-based health centers must negotiate contracts with each participating plan.

We, too, have a requirement in the state contract with the plans that they may make arrangements with the school-based health centers. We have been aggressively pursuing contractual arrangements between the plans and the school-based health centers, but without much success. So far, no contracts have been signed. We have not figured out what carrot or stick will help achieve those contracts. Note that the legislation does not preclude school-based health centers from becoming primary care providers but there is no requirement that plans include them in their primary care networks.

STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP). The lack of success in contracting under HealthChoice is particularly significant because the Maryland SCHIP program has been folded into HealthChoice. Under SCHIP regulations, schools are identified as a place for enrollment. However, the ten percent dollars that may be used for purposes other than insurance will not be available to support direct service delivery. Instead, the state will use those dollars to implement an employer-based insurance program for those families whose families are at 185-200 percent of the federal poverty level.

OTHER BARRIERS TO THIRD PARTY PAYMENTS. Beyond managed care contracting, there are two significant barriers to increasing third party revenue streams: First is the inexperience of most school-based health centers in billing for services. Outside our two largest jurisdictions, Baltimore City and Baltimore County, the centers do not have billing experience. Second, the Maryland Insurance Commissioner ruled this past year that nurse practitioners were ineligible to become part of the primary care provider panel of health maintenance organizations (HMOs). While our office successfully challenged the application of this rule to Medicaid HMOs, the ruling still applies to HMOs serving commercial insurance enrollees.

MENTAL HEALTH. As noted earlier, under Medicaid fee-for-service, Maryland reimbursed for mental health services. Mental health is now carved out of the 1115 waiver and if school-based health centers wish to claim for mental health services, they will have to do so either under the public mental health system using diagnostic codes and appropriately credentialed personnel or as part of primary care. Primary mental health is included in the capitated rate to the PCP under HealthChoice. There is no reimbursement for prevention or early intervention under this current system.

Nine State Strategies to Support School-Based Health Centers: A Making the Grade Monograph. The George Washington University School of Public Health & Health Services. Washington, DC.

HEALTH RELATED SERVICES PROVIDED TO MEDICAID-ENROLLED CHILDREN SERVED THROUGH SPECIAL EDUCATION PROGRAMS. Those services included in the Individualized Educational Plan (IEP) and Individualized Family Service Plan (IFSP), were also carved out of HealthChoice and are reimbursed on a fee-for-service basis. In Baltimore City and Baltimore County, they are billing state Medicaid for "related services" and some of these revenues are being reinvested in school-based health centers, not unlike the situation in Vermont. However, use of these funds is a local decision. The state does not mandate that those dollars be directed to the school-based health centers. Moreover, most of the smaller jurisdictions do not have a large special education population and the funds collected are insufficient to be used for purposes broader than supporting the special education infrastructure and services.

NEW SITE PLANNING FUNDS. Maryland currently has 43 school-based health centers. This year we increased our seed fund used for planning new centers as well as related support services from $75,000 to $225,000. When added to the $75,000 in RWJF dollars, the state has $300,000 it can allocate for this purpose. Additionally, the state directed one million dollars to one of its largest counties, Prince Georges County, to support development of school-based health centers.

PRIVATE DOLLARS. A significant shift from our earlier vision is the greater role we see for private partners. The original vision focused almost exclusively on public funding and public policy setting. Recently, private entities, especially large health care systems, have expressed interest in the school-based health centers. One of these systems is now subsidizing two school-based health centers. We are hoping to nurture this development as an alternative model for supporting school-based health centers in the state.

State leadership

Coordination of our finance strategies has been challenging because until recently we have had three agencies responsible for school-based health centers. This winter that number will drop to two, the Department of Health and Mental Hygiene (DHMH) and the Maryland State Department of Education (MSDE), when my office moves from the Office of Children, Youth and Families to DHMH. While a triumvirate is logistically challenging -- particularly in the area of clarifying the school-based health center model -- it has had the advantage of encouraging much communication among the three key agencies.

Continuous Quality Improvement.

Historically the state has deferred to local initiatives in developing school-based health centers and our initial funding strategy anticipated continuation of that model. As a result we did not develop performance standards nor review the sites in terms of their performance. We have now developed guidelines and quality improvement tools that are suggested best practices; they are not mandated or enforced. Beginning this summer, we have begun to collect data from centers statewide. With the decision that Medicaid is going to be a critical part of school-based health center funding, standards, data collection, and the state's role in oversight will become more important.

Policy effectiveness for local partners

Despite the bumpy road, five new centers opened this year bringing our total to forty-three. Part of the growth is due to our seed fund distribution over the past two

years and our partnerships with private providers. We continue to worry about our ability as a state to sustain these fledgling efforts.

So, are our current state strategies working for our local partners? It is too soon to tell. Before we go to the legislature with our needs, we need a solid year of billing in all the jurisdictions with SBHCs and to document the gap between third party billing and the overall operating cost of a center. We note with concern, however, that our jurisdictions most effective at billing, Baltimore City and Baltimore County, at their best are covering only 30% of the costs of their centers. The remaining costs are currently supported by a mix of local support, grants, and in-kind contributions.

Maryland Health Foundation
As a final note, in 1997 the Maryland legislature established a new foundation to serve as a quasi public/private venture that could pursue grants and develop innovative models for health care in Maryland. The Foundation became more visible this past legislative session when the House of Delegates suggested the Maryland Health Foundation as the enrollment broker for SCHIP. Although the role of the Foundation is still unclear, the Foundation received funds to develop the needed infrastructure for this future role. The Foundation will also help design strategies to assist uninsured Marylanders above 200 percent FPL. We think this entity may serve as a potential mechanism for consolidating the diverse public and private strategies that characterize Maryland's school-based health centers initiative and perhaps catalyze the next phase of school-based health center development.

ROSENBERG COMMENTARY

Maryland developed the most explicit funding strategy of all state school-based health center initiatives. The state said "We are going to re-engineer government via the Local Management Boards and the LMBs will choose to use their dollars for school-based health centers. We are confident that once we have done sufficient education on the value of this add-on service, the LMBs will elect to spend dollars on school-based health centers."

One of the perils was the state had not defined what a school-based health center was because the state had decided that the add-on service was to be defined by the LMBs or their communities. It was a fascinating approach but unfortunately it didn't work. As a result, Maryland is between a rock and a very hard place. On the one hand, you haven't defined a school-based health center so that you can do an appropriate Medicaid managed care interface policy; on the other hand, you have the legislature designating dollars for the Education Department to be involved in school-based health centers because if a school-based health center is an add-on service, it doesn't matter where programs get put because all policy gets decided at the local level and we can put the school-based health center dollars wherever a particular legislator wants them to go.

The question on the table is now that systems reform does not appear to be a viable strategy for financing school-based health centers, how do you re-tool to create a viable financing strategy? One potential strategy may involve the new foundation, the Maryland Health Foundation.

The Maryland Health Foundation appears to be becoming the enrollment broker for Medicaid managed care and SCHIP and its responsibility is to help beneficiaries with choice of plans and access to care. Part of what might be encompassed within their responsibility is to make sure that access for kids is appropriate and sufficient. And part of that role is the foundation could be the one to define what a school-based health center is; let the foundation be the one to serve as the broker between managed care plans and school-based health centers, using the language of access and choice.

Let me emphasize another point: The state operated on the premise that the localities had all the knowledge on how a school-based health center should be defined. The marketplace people tell us that all wisdom lies in the marketplace and that the marketplace will self correct when necessary. What they were trying to say in Maryland was that all wisdom lies in the localities. And that was a flawed assumption. The LMBs have no more wisdom than anyone else. A corollary to that flawed premise was an absence of understanding that for an add-on service to work, you have to demonstrate to constituents that there is a benefit for them or their kids. It may be an access benefit; it can be a reduction in sex, drugs and rock & roll, but there has to be an explicit, understood benefit.

LOUISIANA: BUILDING A STATE-SUPPORTED NETWORK OF SERVICES FOR SCHOOL-AGE CHILDREN

SYLVIA STERNE:

The financing strategy

Louisiana's original financing strategy involved all the strategies mentioned so far, Medicaid reimbursement, pooled funding, use of block grants, a local match and some state funds. In the first couple of years we even spent time on Medicaid managed care, first on an 1115 waiver application that was rejected by HCFA, then on a 1915(b) waiver application which was approved. In the latter, all we got in the state's requirements for the plans was "encouragement" to Medicaid managed care organizations to contract with school-based health centers. Since the 1915b pilot is being put in place in an area that does not have school-based health centers, we still aren't doing anything with managed care.

What we've learned over time is that our best finance strategy is a political one. School-based health centers work with their legislators who become advocates for funding more centers. The local sites have done a great job and as a result Louisiana has an annual state appropriation of $3.25 million to support school-based health centers. And this is added to a Maternal and Child Health Block Grant allocation of between $600,000 and a million annually plus Making the Grade funds and local match contributions.

State leadership

The strategy for school-based health centers has been coordinated by the Office of Public Health. The policy has worked: the number of school-based health center sites has increased from four in 1991 to 30 in 1998. About 60 to 65 percent of each site's budget is derived from state resources. Local match is running between 30 and 35 percent; Medicaid revenue is only about three percent which is appalling because about a third of the centers' population is Medicaid eligible. However, there are barriers to becoming a Medicaid-enrolled child in our state, one of which is a 38-page application form. We also have sites with staff that are not trained to bill Medicaid.

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Institutions receiving state grants for school-based health centers are required to reinvest any third party reimbursement funds back into the centers.

Effectiveness of state policy for local partners
How is the strategy working for local partners? It all depends on the particular partner. For example, one of our local partners found that when their sponsors saw how much money was being appropriated by the legislature, the sponsors pulled back on their contributions. On the other hand, grant funding has been essential for establishing new centers and local sites obviously benefit from our increased grant support.

The comprehensive model
Maintaining the comprehensive model has been easier in Louisiana because that is where we started. At the very beginning the state defined a comprehensive model for the centers. State grants require staffing to include at least a half time mental health professional, a part-time or full-time nurse practitioner, physician and registered nurse and an administrator to pull it all together and to work with the community.

Insisting on the inclusion of mental health services has been very helpful legislatively because it makes clear our focus on risk factors. This year we have increased efforts to identify which students use the center as their medical home. The State Program Office has informed all its grantees that they must provide a certain percentage of primary care services for these students during the year.

Relationship to SCHIP
School-based health centers did well during the SCHIP hearings in Louisiana. Everyone who testified before the Governor's commissioner, whether they represented a university or a provider group, included school-based health centers in their strategy. We are part of the delivery system in the state. Medicaid is going to be extended to kids up to age 18 with family incomes up to 133 percent of the federal poverty level in year one of a three-year expansion to 200 percent FPL. In Louisiana we've learned that there are 150,000 - 200,000 children eligible for Medicaid but not enrolled. This expansion has the potential to turn our financing. Conversely, a fear is that maybe the kids won't come when they have other options. I don't think so but that remains to be seen. I think the local school-based health centers and their sponsors want to make this a good service. They have done parent satisfaction surveys that document their support. Just the convenience of being where the child is and work-time saved by parents who don't have to come pick up children is all perceived as a great benefit. So I think we're going to be okay.

Reinventing public health
We've been talking about core public health functions in our agency for five years and we are still a top-down state where every parish health department is run by a state health department nurse and they are still providing maternal and child health services and I don't see any of that changing. School-based health centers are seen within the Office of Public Health as doing core public health functions.

School health services and our relationship with the department of education
This has not been a strength. There has not been a health presence within the State Department of Education for more than ten years. School nurses are employed at the parish level by the school system; some work beautifully with school-based health centers; others do not. And a lot of parishes do not have school nurses.

Louisiana has been really successful in defining itself as a public health function. You have been extraordinarily successful politically. And SCHIP has the potential to rock your boat because as Medicaid increases due to the outreach efforts and broader eligibility criteria associated with the passage of SCHIP, the school-based health centers are now going to have to prove their worth. And if the kids vote with their feet and go to the private physicians, who will see them now that they are insured, can you sustain yourself politically? Your low Medicaid enrollment rates made Medicaid a non-issue until now but SCHIP is going to change that dramatically. If the kids start out-migrating, you will be in trouble. But you've done a great job with the strategy you have chosen.

CONNECTICUT: RE-TOOLING AN ESTABLISHED STATE PROGRAM, PART II

LYNN NOYES:

Connecticut has either copped out as to what its model for a school-based health center is or has adopted a multiple personality approach. Even in documents we use to educate managed care, we talk about school-based health centers as integrating medical, public health and social service models. We are everything to everybody. That has some benefits but also some struggles.

The financing strategy

GRANT SUPPORT. Our financing strategy consists of several components: One is a grants program that funds 45 of the 51 school-based health centers in the state. We have a state general appropriations budget of just under $4.5 million, plus a small amount of Maternal and Child Health Block Grant funds. Periodically we also have special project money for one or two years. This year we have an additional $800,000 to support sites whose local foundation grants have ended as well as to establish new sites in Waterbury and East Hartford.

PATIENT CARE REVENUE. For a long time the state did not support third party billing by school-based health centers. The state's position was that having paid for services via a grant, third party payment, especially by Medicaid, would constitute double-dipping. Further, the state Department of Public Health did not want insurance status or confidentiality concerns to be a barrier to access to care. But in 1994 the state concluded that grant support was not covering full costs for the centers and agreed that the grantees could bill third party payers. And, of course, just shortly after that time, the Medicaid program converted to managed care and capitated arrangements, and the school-based health centers entered a whole new world of contracting.

Medicaid managed care contracting became an unbelievable challenge. Initially we had 11 plans participating in Medicaid managed care plus ten mental health and five dental health carve outs. In all there were more than 20 - 30 contracts to negotiate between the plans and sponsors of the school-based health centers. It has taken two and a half years but nearly all the contracts are in place. While it helped that the state RFP required plans to include school-based health centers in their networks, we have learned that that was just the first step. Now, of course, we have to start the process all over again because the state just launched its SCHIP program, HUSKY (Health Care for Uninsured Children and Youth) a non-Medicaid insurance product with a more limited service package than Medicaid and

required co-pays. On the positive side, the centers will have only five plans with which to negotiate their HUSKY contracts.

Medicaid managed care dollars are beginning to accrue to the centers. To date, the results of those contracts have ranged from a negative ten percent due to the cost of implementing billing procedures up to a positive ten percent of operating costs. Most health centers are realizing five percent of their operating costs or less.

Despite contract struggles, some creative things have occurred. Oxford Health Plan contributed a substantial amount of health education materials for an asthma support program through a school-based health center in Stamford. We're also discussing with HealthRight, another Medicaid managed care plan, the possibility of an EPSDT project in New London and Groton. EPSDT compliance in Connecticut has historically been low, particularly for adolescents. Under this arrangement HealthRight will utilize its outreach workers who do home visiting to inform parents about EPSDT. If the children are not already enrolled in the local school-based health center, the outreach worker will enroll them. HealthRight will provide the school-based health center with a monthly list of its enrollees who need an EPSDT exam. The school-based health centers will provide the service and the plans will pay the centers.

A few centers have had some success in billing private insurers. One of the challenges with commercial insurance is that the insurance reimbursements are sent to the families and the families, who have not been asked to pay upfront to the centers, don't always want to turn those payments over to the centers. Moreover, protecting confidentiality remains a concern.

LOCAL SUPPORT. Since 1985, the beginning of our school-based health center program, we have required a 25 percent local match. Most of that value comes from in-kind services from sponsor agencies. Historically we have awarded between 50 - 90 percent of core funding to grantees. In light of the changed policy on third party reimbursement, we have begun to reconsider our view of core funding. But changing that policy of nearly full funding leads to a number of hard questions: What do you use as the criteria for funding decisions? Do you use a fixed percentage of the budget? Do you consider the potential number of users or actual users? What about the percentage of Medicaid enrollees and likely third party payments? Then there are the political realities in terms of how do you de-fund a center which may not be performing up to snuff but happens to have the chair of appropriations or the chair of public health as its representative in the state legislature?

State leadership

The Department of Public Health is the lead agency for school-based health centers. We award grants to local entities to organize school-based health centers and to hold the license for the facility. We monitor their contract with us, do quality assurance, collect data and perform analyses, and facilitate policy discussions. Periodically we also get directives about whom should get grant dollars and how much they should get and we work closely with these new participants in developing school-based health centers. The state has taken a strong role in supporting the centers as providers of care to school-age children. When the Department of Public Health worked on the 1915(b) waiver program establishing Medicaid managed care, school-based health centers were the only provider type named an essential community provider, meaning they were the only provider with whom the Medicaid managed care plans must contract.

Our legislature created an oversight council to look at the implementation of Medicaid managed care; fortunately the school-based health centers have a number of supporters on

that council who are very concerned about the safety net providers -- community health centers, local health departments and school-based health centers -- and they have played an advocacy role to make sure school-based health centers don't fall through the cracks during implementation.

Continuous Quality Improvement (CQI)
In Connecticut we are a lot better at CQI in the non-finance areas. We have contracts that require billing, but we have not monitored performance as well as we should. Some have put excellent systems into place; others are saying, "Well, we've got our contracts and I've sent out some bills," but a real billing system is not in place. And there are many school-based health centers that came to billing kicking and screaming. We will shift from putting systems in place to operationalizing the systems in the next year.

We also provide technical assistance and training. We have engaged experts to do training on how to negotiate with managed care or how to decide whether to set up a billing system or contract it out. We've done a lot of work with our mental health professionals around documentation to meet NCQA (National Committee on Quality Assurance) accreditation standards Connecticut school-based health centers must be licensed as outpatient clinics or hospital satellites. The licensure division in the Health Department is responsible for this activity. The managed care plans are responsible for credentialing all participating providers so meeting those paper requirements as well as professional standards is another challenge for our local partners. Each plan has its own credentialing forms and requirements so they must be individually completed for each plan. This has been a large administrative burden.

Effectiveness of state policy for local partners
Maybe the most important thing that can be said is that we're still here. School-based health centers started in the mid-1980s under a Democratic administration. They were sustained and expanded a bit under an Independent governor. Four years ago a Republican governor was elected who promised to eliminate the state income tax and reduce government spending. As a result a number of long-standing state programs were eliminated, but school-based health center grant dollars survived. The four new centers that opened during this four-year period have been funded by the Robert Wood Johnson Foundation. This year the legislature added an additional $800,000 to our budget which, as noted previously, will sustain some existing sites that are losing private foundation support as well as provide start-up dollars to fund two new centers.

The grants have kept things functioning. The data requirements probably aren't seen as helpful to local sites though they are important to the state. However, since accountability is more and more important to the state legislature, the training we have provided in data management, we believe, will be viewed as an essential benefit.

Coordination issues with the child's medical home
At this point we do not have a good sense of whether this is an issue or not. Some providers like working with the school-based health centers and some do not. Now that we have contracts in place, we are going to learn more about coordination between the school-based health centers and medical homes. Prior to Medicaid managed care, nearly half the students using Connecticut's school-based health centers had no medical home. We will be monitoring to see if this changes with Medicaid managed care and HUSKY.

Re-inventing public health
The state health department does not provide direct service delivery, unlike Louisiana. As school-based health centers are not a population-based service, it is also difficult to

market them as a core public health function, even though they do perform assessment and assurance functions within their school communities. A major debate that is going on in the health department is whether recent changes in the health care system require changes in publicly funded health services. That is one of the things that school-based health centers will have to address. Among some legislators there is a feeling that with HUSKY all children have been covered so why should we continue to invest in a delivery system. We will have to come up with a clear answer to that question.

Linkages with school health services .
We collaborate but there is no mandate for coordination. School health services in Connecticut are under State Department of Education regulations and school nurses are employed directly by school districts or through local health departments.

ROSENBERG COMMENTARY
One of the problems with being everything to everybody is that as you get universal health insurance for children, the question is raised why the states should pay to support medical homes when the market is ready to step up to the plate. There is no compelling answer to that question. Moreover, the report that your centers are netting less than five percent of their operating costs from the managed care contracts suggests another difficulty with being everything to everybody, that is, the school-based health centers have no incentive to make the Medicaid managed care system work for them. It is too hard and returns too little. Therefore the centers do not continue to play the game and that lets the plans off the hook despite your best efforts.

Connecticut has two challenges as it tries to walk this complex middle road: one is to demonstrate that you are adding value above and beyond what the market will under universal coverage; and two is to make sure that the administrative costs of providing everything for everybody does not overshadow the benefit that you are allegedly adding. During the Clinton debate, one of the questions posed was why do you need safety net providers once you have provided everyone with health insurance? We still don't know the answer to that question but the question is still out there.

COLORADO: SHAPING PRIORITIES IN A MARKET-ORIENTED ENVIRONMENT

BRUCE GUERNSEY

The state financing strategy.
Colorado's strategy to support school-based health centers has been strongly market-oriented. Our primary activity has been to promote the availability of revenue streams that local communities and families can direct towards the centers and to incrementally identify dollars that can pay for uncovered costs. Behind this strategy is a belief that at least in larger Colorado communities, there are sufficient resources -- whether from a local hospital or school budget or foundation -- to support a significant portion of a school-based health center budget.

PUBLIC DOLLARS. In 1997 our legislature passed three pieces of legislation that have potential for creating revenue streams for school-based health centers. We have been successful in influencing the state rule and regulations implementing these laws such that they are supportive of school-based health centers that can serve as medical homes.

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- The first, Senate Bill 5, will increase Medicaid managed care enrollment to 75 percent of Medicaid beneficiaries by the year 2000. Most importantly for the school-based health centers, the legislation defines the centers as essential community providers (ECP) and encourages managed care organizations contracting with Medicaid to make good faith efforts to contract with ECPs that provide services in areas where they are enrolling recipients.
- The second, the Children's Basic Health Plan which has become Child Health Plan Plus (our SCHIP), implements insurance expansion through a private model. It also uses the ECP definition of Senate Bill 5. Given the high rate of uninsured kids seen by many of our centers, CHP Plus has great potential to increase their third party revenue.
- The third, Senate Bill 101, "Medicaid Reimbursement for Schools," authorizes participating school districts to become Medicaid providers. Thirty percent of the dollars recovered could be used by the schools to purchase health insurance for students or purchase primary care services directly for low income students. This means Colorado schools could use their participation in Medicaid to help support their school-based health centers. Unlike Vermont, however, the schools aren't required to do so.

Mental health Medicaid is a carve-out that is fully capitated. A lot of these dollars are contracted to the traditional mental health centers. This is where the in-kind support for school-based health centers comes in. To get mental health services into the school, school-based health center providers must work with the local mental health capitated provider. In many places they have been very, very successful. Other programs haven't done as well and have used grant funds to hire these services. It is now in the state-issued Request for Proposals that mental health providers are encouraged to provide services through the schools.

PRIVATE MANAGED CARE INITIATIVES. We have some private initiatives that are significant. Kaiser School Connections is a dues subsidy program supported by Kaiser Colorado. Three school-based health center programs participate through 10 of their sites. The initiative basically represents a splitting of the primary care capitation -- with the school-based health centers receiving 60 percent of the cap, and 40 percent for Kaiser. Kaiser provides the medical supervision in collaboration with the school-based health centers. This has been an interesting experiment. One of our programs got rolling quickly and exceeded its enrollment goal, another is getting up to speed and a third is still struggling with enrollment. Success may be based on the structure of copayments and ability to assure third party payments. We are now in the process of an evaluation which will track HEDIS measures, cost and utilization data, as well as enrollment and disenrollment figures. Certain numbers look really good and some are troubling and portions of the evaluation provide an opportunity for implementing quality improvement activities.

Another private initiative is with PacificCare in Denver. PacificCare provides a grant to participating school-based health centers in return for HCFA 1500 billing data to build a utilization history as a basis for an on-going capitation arrangement with the school-based health centers.

OTHER SOURCES OF SUPPORT. Other financing areas that are important include local in-kind support and private foundation participation. We require our grantees to secure substantial local in-kind contributions. Local dollars provide a financial base, help fund the mental health component, and document community support.

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Foundation dollars continue to be important. School-based health centers receive contributions from United Way, the recently-created Rose Foundation, HealthOne, Blue Cross/Blue Shield and others. Blue Cross will likely be privatized next year, resulting in the creation of a new, very large foundation. We hope this foundation will help support the centers as well.

We have also secured one-half million dollars from Maternal and Child Health and Preventive Health Services block grant funds. One thing we have not gotten yet is state general fund dollars. Therefore it appears we are going to need other sources to subsidize these centers. There will always be uninsured children and there will always be uncovered services, especially in the health promotion arena.

State leadership.
An interagency steering committee formed of all the state agencies involved in supporting school-based health centers provides overall guidance to the state initiative. The state association for school-based health centers also has a seat on this as do several of the plans. My office is based in the Colorado Department of Public Health and the Environment. It has been strongly behind efforts to make school-based health centers available in areas in which adolescents, especially, are underserved. We have also benefited from a close relationship with the Department of Health Care Policy and Finance, and while there has been turnover in our liaison, those very bright people went off to other interesting positions that have been of great value to school-based health centers -- a private foundation and a large managed care plan.

State association for school-based health centers
A relatively new program component is making a big contribution to the state's financing strategy. The Colorado Association for School-based Health Care (CASBHC) is a provider association that includes nine of the twelve entities that sponsor school-based health centers. CASBHC is an independent non-profit organization that has about $200,000 in funding for the current year. Getting back to Steve's comments about our learning the lessons from Henry Ford, CASHBC, with support from the federal Bureau of Primary Health Care, is exploring the opportunities for economies of scale in various aspects of school-based health center management.

CASBHC has developed standards for three levels of certification for school-based health centers. The certification categories describe the service package for different types of school-based health centers without forcing them into a one-size-fits-all approach. Hopefully, the categories will help managed care organizations understand what they can expect from various types of school-based health centers. Certification categories cover scope of services, physical plant, availability, quality assurance, and financing. Each school-based health center has been certified as level I, II or III. Level I and II centers should have the capacity to contract with HMOs directly; level III centers would probably be considered an add-on service of some sort, depending on the services they are providing. Along with these levels, CASBHC has developed some quality assurance protocols and clinical outcome indicators that are based on HEDIS measures. CASBHC is now approaching HMOs to secure contracts for reimbursement for care to children enrolled in Medicaid and the SCHIP.

Effectiveness of policy on local partners
In terms of effectiveness, we have gone from 18 sites in 1994 to 31 in 1998, although we lost five of the weaker programs along the way. We fund 10 programs with the RWJF

dollars; we decrease their funding each year. Each contractor has developed a unique replacement strategy for the dollars it is losing as foundation support draws to an end.

The need for state support

I noted earlier that I believe we need state resources to complete the funding picture for most school-based health centers. One area where our project has not done what needs doing is developing a communications strategy to cultivate a strong base of public understanding which might make a legislative initiative feasible.

Over the past four years we have increased state resources dedicated to school-based health centers from about $130,000 in MCH funds to over $500,000. However, school-based health center budgets around the state are covering only six to eight percent of their operating costs with patient care revenues. The best recovery of third party revenues is about 25 percent. These centers are able to serve as primary care providers. They bill families, go after every billable service and still collect only 25 percent of their operating costs. This is why I'm convinced we need state support as well as strong in-kind contributions. I believe that focusing on patient revenues does detract from paying attention to such services as preventive services and health promotion. It's a real trade-off and the pursuit of reimbursement has consequences for how much time and energy we have to invest in prevention programming.

Re-inventing public health

This is a big issue in my agency. We are in the process of redirecting resources and direct services to infrastructure, policy development and filling services gaps. We now look at a continuum of models, including school health, public health, school-based health centers, primary care. However, the agency hasn't decided where it wants to come out in terms of defining what public health should be in Colorado.

To the future

One last comment about school-based health centers and the state health department. Environmental factors include a strong fiscal social conservatism, term limits on one-fourth of the legislature and the governor's office, and potential state agency leadership changes. Therefore, as we consider how to structure the school-based health center initiative beyond the Robert Wood Johnson Foundation grant, we are exploring the possibility of a strategic partnership with The Children's Hospital in Denver. It has a regional focus, a strong lobbying capability and the state, of course, brings its expertise and partnerships that it has developed in working on financing. We think a public-private partnership may serve us well as a basis for a strong state collaboration.

ROSENBERG COMMENTARY

I want to do a little compare and contrast. If in Maryland I had a new kind of Democrat who believed that local people knew truth and that the Local Management Boards would discern truth and fund school-based health centers; in Colorado I had a different type of new Democrat, one who thought that the market knew truth but that the role of government is to write the rules of the road and let the market drive on the road. So what I would say about Colorado is that you have been remarkably successful in the development of private partnerships. On the other hand it is interesting to hear you say that you need state grants in order to continue the operation of school-based health centers, because then we move from being a new Democrat to being an old Democrat in looking to government as a source of support.

Colorado has probably come further along than others in defining what a school-based health center is and defining its various gradations and that's part of the paradigm of "let's write the rules of the road and let the market drive on it." Despite being able to define them as clearly as you have, I don't hear that you've been able to define a concomitant financing piece that is public health-specific to each of the three levels that would then need the state grant dollars. So what I would encourage you to do is that if you are going to move from a new Democrat to an old Democrat approach to financing, then the next step is for each of your three levels of school-based health centers to identify that public health component for which you need legislative dollars in order to keep them alive; figure out the value that that component adds, and figure out the cost of that component. Then go to the legislature asking for that specifically targeted by type of school-based health center so you can still let the market drive freely on the roads that you've done a great job of building. Your risk of going for the state grant dollars is that the market walks away because it says, "This has now been funded by the state." It is the opposite of Lynn's problem in Connecticut where she's had an old style Democrat model for more than ten years and now she's trying to bring in the market. Colorado will need to be careful and cogent as you seek those state dollars. I suspect you have both the data and infrastructure that will enable you to make a plausible case for state dollars.

I have a final reflection on the experiences of all nine Making the Grade states and their efforts to secure access to public and private funding streams as well as generate state fiscal support. At present, the onus appears to be on school-based health centers to prove their worth, a task which will require documentation of the numbers of children they are serving, their insurance status, and services provided to them. This information will provide the evidence needed to lobby for inclusion in health plan networks, and for state or local revenues to cover those health promotion and education services that are often excluded from insurance coverage.

Do not confuse political support, which also is essential to secure public dollars, with whether you provide a necessary service. To those of you who currently enjoy strong political support but whose mission is less than clear, I can only urge you to make good use of this time to do the data gathering essential to document functions you are fulfilling.

A guide for reviewing state policies as they support the financing of school-based health centers

This guide was used by presenters in describing their state strategies to support school-based health centers.

Please describe your state's SBHC financing strategy in terms of the following components

1. **Process:**

    a) What is the explicit finance strategy?

    b) What state agency coordinates that strategy (i.e. Medicaid, DOH, Governor's office)?

    c) What is the Making the Grade role in the CQI on that policy?

2. **Outcomes:**

    a) Is the policy proving to be effective as measured by number of new sites, percent of each site's budget derived from state resources, percent of visits reimbursed by third party payers, patient care reimbursement levels, and recycling of reimbursed funds?

    b) Are state strategies working for MTG local partners?

    c) Does the finance strategy facilitate or impede a comprehensive school-based health center model? Could you provide examples?

    d) Does the strategy facilitate or impede school-based health centers coordinating with students' medical homes?

3. **Related initiatives**:

    a) CHIP:
    What has been the input of SPO in CHIP planning and policy? What has been the relationship between MTG local sites and CHIP program and policy? Are there differences between Medicaid and CHIP in terms of their treatment of SBHCs?

    b) Reinventing or Reorganizing Public Health:
    Many states are re-thinking public health functions, especially the role of public health agencies in the provision of health services. If these conversations have occurred in your state, what has been the role of the MTG office? To what extent have SBHCs participated in the re-thinking of public health and are they players in the reorganized system?

    c) School Health Services:
    Has there been state policy on the relationship between SBHCs and school health policy? How are SBHCs in your state interacting with school health services?

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THE GRADE: STATE AND LOCAL PARTNERSHIPS TO ESTABLISH SCHOOL-BASED HEALTH CENTERS

National Program Meeting
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Making the Grade: State and Local Partnerships to Establish School-Based Health Centers

Annual Meeting
Wednesday, June 24, 1998
Sheraton Gateway Hotel, Los Angeles International Airport

AGENDA

7:30 am - 8:00 am *San Clemente Room*	Continental breakfast
8:00 am - 12:30pm	State SBHC Financing Strategies
San Clemente Room	Facilitator: Steve Rosenberg, Rosenberg and Associates, Point Richmond Ca.
	Julia Graham Lear -- *Evolution of state SBHC finance policy*
	SPO Directors -- *15-minute presentations from 9 directors on status of state SBHC financing policy*
12:30 pm - 1:30 pm *Santa Rosa Room*	Lunch
2:00 pm - 3:30 pm *San Clemente Room*	Clinical Care Issues
	Linda Juszczak, Clinical Services Consultant *Report on site visit findings concerning the provision and documentation of clinical care -- To focus on the strengths and challenges confronting SBHCs and on how to improve the utility and quality of care.*
3:30 pm - 4:30 pm *San Clemente Room*	Data Discussion
	NPO Staff: *Review of staffing and service data from the 45 local sites. Focus on financial data to be required during the 1998/1999 year.*
6:00 pm *Hotel Lobby*	Bus departs for dinner at Gladstone's Restaurant in Malibu

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